

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. A copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

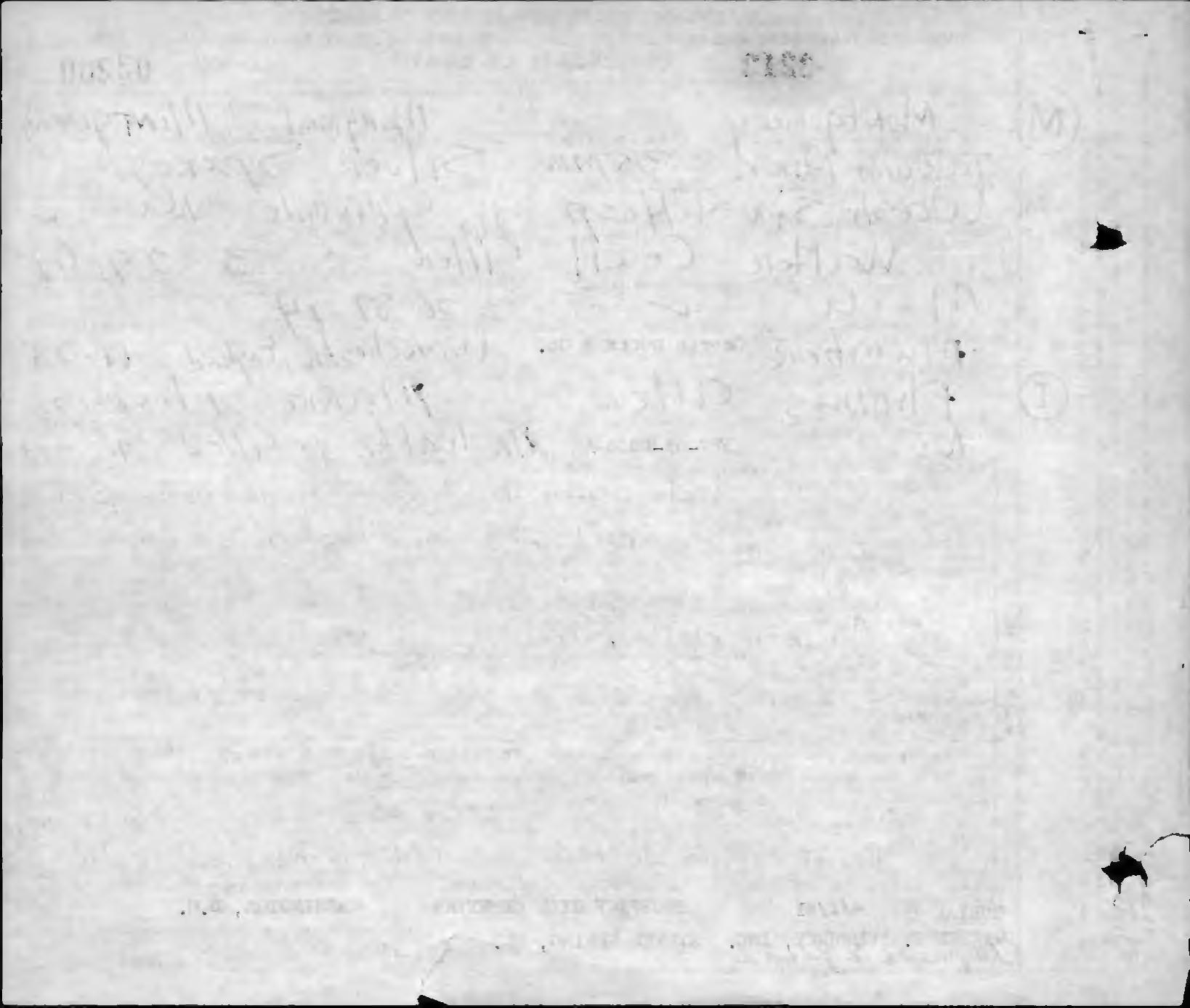
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3212

CERTIFICATE OF DEATH

03260

1. PLACE OF DEATH a. COUNTY		MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		35 min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Takoma Park				Silver Spring		Montgomery	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Wash Sv & Hosp		d. STREET ADDRESS		215 Granville Ave	
First Middle				Last		Month	Day
3. NAME OF DECEASED (Type or print)		Walter Cecil		Allen		3	29
4. SEX		m w		5. COLOR OR RACE		6. DATE OF BIRTH	
7. MARRIED		<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		7. AGE (In years last birthday)	
WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>		3-20-87		74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Plumber		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
George Dutts & Co.				12. CITIZEN OF WHAT COUNTRY		Worchester, England U.S.A.	
13. FATHER'S NAME		Thomas Allen		14. MOTHER'S MAIDEN NAME		Maria Thomas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give rank or grade of service)		No		16. SOCIAL SECURITY NO.		17. INFORMANT	
				377-03-0058-A		MR Walter F. Allen Address Same as deceased	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute coronary thrombosis with myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH	
		420.1 Conditions, if any, which gave rise to immediate cause (b)				1/2 hr	
		DUE TO Generalized and coronary atherosclerosis (c)				several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		Carcinoma of the rectum				19. WAS AUTOPSY PERFORMED?	
20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from... February 1961 to March 29, 1961, that (I) (we) last saw the deceased alive on... March 29, 1961, and that death occurred at 7:25 P.M. from the causes and on the date stated above.							
22. SIGNATURE		Bennet A. Porter, Jr., we		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type)		Bennet A. Porter, Jr., M.D.		22d. ADDRESS	March 29, 1961		
23e. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City, town or county)	(State)		
BURIAL		4/1/61	PROSPECT HILL CEMETERY	WASHINGTON, D.C.			
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
Warren E. Pumphrey, INC.		SILVER SPRING, MD.		DATE APR 3 '61	Arthur S. Thomas		
Raymond J. Zelka							



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3213

CERTIFICATE OF DEATH

03201

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

c. LENGTH OF STAY IN lb

134 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

U. S. Naval Hospital

3. NAME OF
DECEASED
(Type or print)

First
Edmund

Middle
John

ANDERSON

4. SEX

Male

6. COLOR OR RACE

Caucasian

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

10-28-17

9. AGE (In years
last birthday)

43 yrs.

10. IF UNDER 1 YEAR
Months Days

Hours Min.

e. IS RESIDENCE
ON A FARM?
YES NO

11. Month
March
Day
27
Year
19 61

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Mariner

10b. KIND OF BUSINESS OR INDUSTRY

U. S. Navy

11. BIRTHPLACE (County & State, or foreign country)

New York

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Edward Joseph ANDERSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

Yes

WWII-Korean

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Ida Amele ULRICH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic adenocarcinoma (Primary unknown)

INTERVAL BETWEEN
ONSET AND DEATH
6 MOS

199 X DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from Nov. 9, 1960 to March 27, 1961, that (we) last saw the deceased alive on March 27, 1961, and that death occurred at _____, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

R. C. THOMAS, LT, MC, USN

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED
3-27-61

22d. ADDRESS

U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION + 23b. DATE THEREOF

REMOVAL (Specify)

Burial

March 30, 1961

23c. NAME OF CEMETERY OR CREMATORIAL

Arlington National

23d. LOCATION (City, town or county)

Arlington

(State)

Virginia

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Everly-Wheatley, 1500 W. Braddock Rd., Alexandria

Va.

25a. REC'D BY REGISTRAR

MAR 30 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Krause

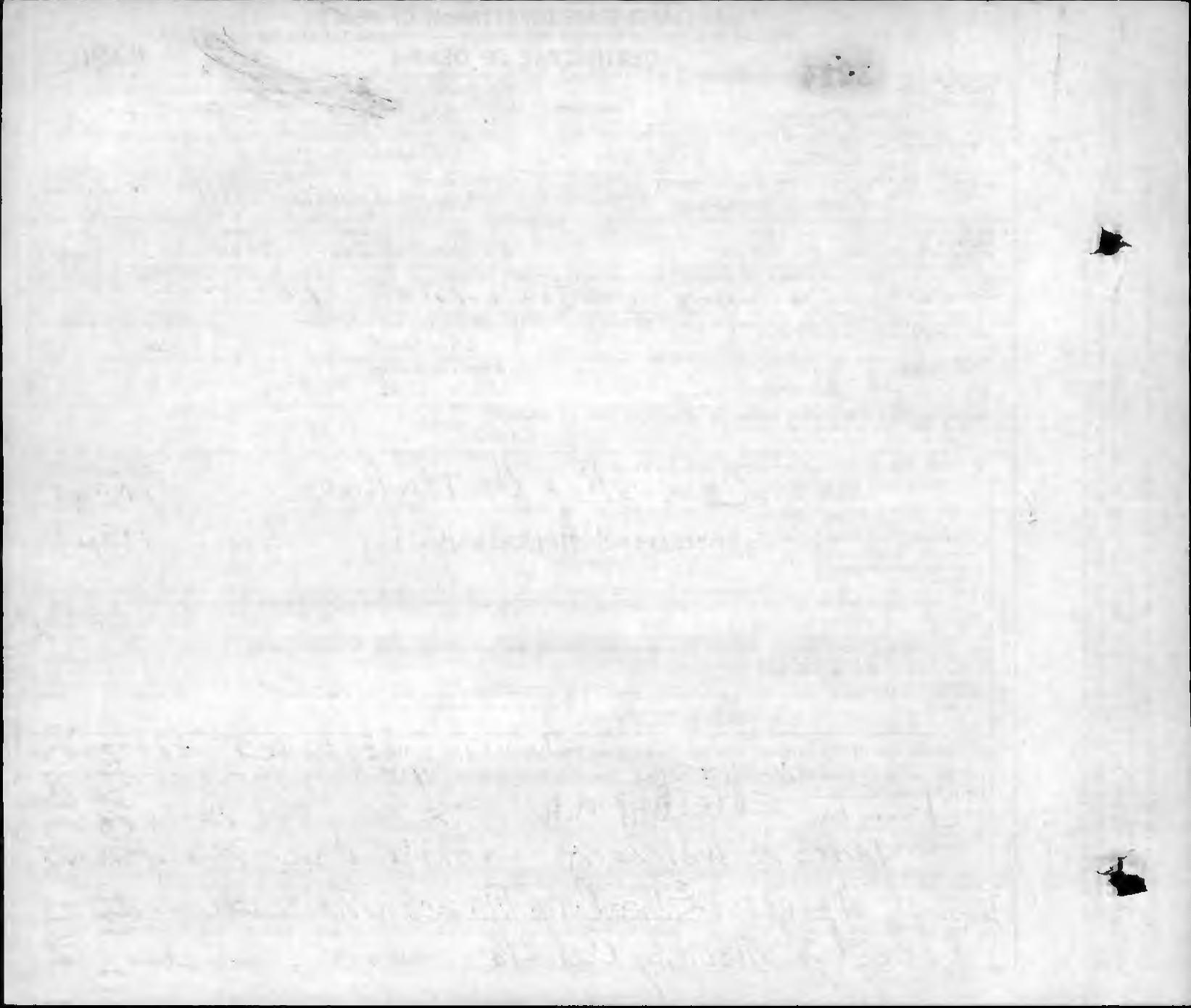
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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03202

3214		Item 2 Film C282 3/11/61 m			
1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Montgomery		MONTGOMERY		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Wheaton		85 mo.		Wheaton Arlington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Wheaton Nursing Home		1200 S. Courthouse Rd.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH Month Day Year
Kathryn				Barber	7 MAS 5 1961
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday) yrs.
Female		white		June 27-1818	82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Ireland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John Burke		Elizabeth Mallay		USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		20 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Generalized Arteriosclerosis			
DUE TO (b)		10 yrs			
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19					
21. I certify that (I) (this hospital) attended the deceased from June 12 1960 to March 5 1961, that (II) (we) last saw the deceased alive on March 5 1961, and that death occurred at 11 AM, from the causes and on the date stated above.					
22a. SIGNATURE		ATTENDING M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
James M. Whitlock				March 6, 1961	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		7717 Randall Ave Indianapolis Indiana	
JAMES M. WHITLOCK		7717 Randall Ave Indianapolis Indiana			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23d. LOCATION (City, town, or county) (State)	
Removal		Mar 8 1961		Martinsville Indiana	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR	
Robert J. Murphy Cr. & Va				DATE MAR 9 '61	
				25b. REGISTRAR'S SIGNATURE	
				Arthur & Evans	



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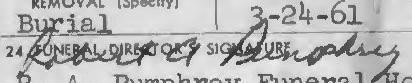
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VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3215

03203

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 1 day		a. STATE Maryland		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				b. COUNTY Montgomery		
3. NAME OF DECEASED (Type or print) Lida		First	Middle	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		
4. DATE OF DEATH March 22 1961		Last	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-10-73		
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		
13. FATHER'S NAME William WILLIAMS		14. MOTHER'S MAIDEN NAME Zadie KASSON		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank and dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT (D) Mrs. Frances W. B. Miller, same as #2 above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction, myocardium		INTERVAL BETWEEN ONSET AND DEATH 12 Hours				
DUE TO 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Arteriosclerotic heart disease		Years				
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Volvulus, cecum		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OP. CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (H) (this hospital) attended the deceased from... March 21 1961 to... March 22 1961 , that (H) (we) last saw the deceased alive on... March 22 1961 , and that death occurred at... 6:45 AM , from the causes and on the date stated above.						
22e. SIGNATURE 		M.D.	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	3-22-61 22b. DATE SIGNED XXXXXX
22c. PHYSICIAN'S NAME (Type) G. A. MAGID, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-24-61	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National	23d. LOCATION (City, town or county) Arlington	(State) Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md.		25a. REC'D BY REGISTRAR MAR 24 '61	25b. REGISTRAR'S SIGNATURE 	

10/25/44

10/25/44

10/25/44 - 10/26/44

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10/25/44

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M

10/25/44 - 10/26/44

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3216

CERTIFICATE OF DEATH

03204

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN lb 30 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 200 E. Wayne Avenue		d. STREET ADDRESS 200 E. Wayne Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Henry W. Barrows		First	Middle	Last	4. DATE OF DEATH March 9, 1961	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 10, 1886		9. AGE (In years lost birthday) 75 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor		10b. KIND OF BUSINESS OR INDUSTRY Gen'l Conf, S.D.A.		11. BIRTHPLACE (State or foreign country) Randolph, Vermont		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Willis Barrows		14. MOTHER'S MAIDEN NAME Jennie Sumner		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Cerebralclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 157X (b) Cerebrovascular DUE TO (c) Paroxysmal INTERVAL BETWEEN ONSET AND DEATH 3 months			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 15 to 1961 , to March 9, 1961 , that (I) (we) last saw the deceased alive on March 5, 1961 , and that death occurred at 9 AM , from the causes and on the date stated above.		22b. DATE SIGNED							
22a. SIGNATURE Lyle Williams		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
22c. PHYSICIAN'S NAME (Type) Lyle Williams		22d. ADDRESS 8700 Colesville Rd, Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 13, 1961		23c. NAME OF CEMETERY OR CREMATORIAL George Washington Cemetery		23d. LOCATION (City, town, or county) Burke, Prince George County, Md.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur Walters		ADDRESS 254 Carroll St, N.W. Wash, D.C.		25e. REC'D BY REGISTRAR MAR 13 '61		25f. REGISTRAR'S SIGNATURE Arthur S. Thomas			

815C

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3217

03205

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN [If outside corporate lim ls, write RURAL and give nearest town]

Bethesda (Rural)

c. LENGTH OF STAY IN 1b

MARYLAND

24 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

U. S. Naval Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Katherine Melvina

5. SEX

6. COLOR OR RACE

Female

Caucasian

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Maryland

13. FATHER'S NAME

Kenneth R. BASS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service)

No

16. SOCIAL SECURITY NO

17. INFORMANT

None

14. MOTHER'S MAIDEN NAME

Lucille M. DUGIE

Address

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While at work Not While at work
p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (this hospital) attended the deceased from Feb. 20 1961 to March 16, 1961 that (we) last saw the deceased alive on March 16, 1961, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

L. G. THORNE, LT, MC, USN

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22d. ADDRESS

22b. DATE
SIGNED
3-16-61

U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)
REMOVAL 3-18-61

23b. DATE THEREOF
3-18-61

23c. NAME OF CEMETERY OR CREMATORIUM
Seaside Memorial Cemetery

23d. LOCATION (City, town or county)
Gulfport, Mississippi

24. FUNERAL DIRECTOR'S SIGNATURE

R. H. PUMPHREY

ADDRESS

7557 WISCONSIN Ave BETH.MD

25a. REC'D BY REGISTRAR

DAT MAR 21 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Thorne

2351221X



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

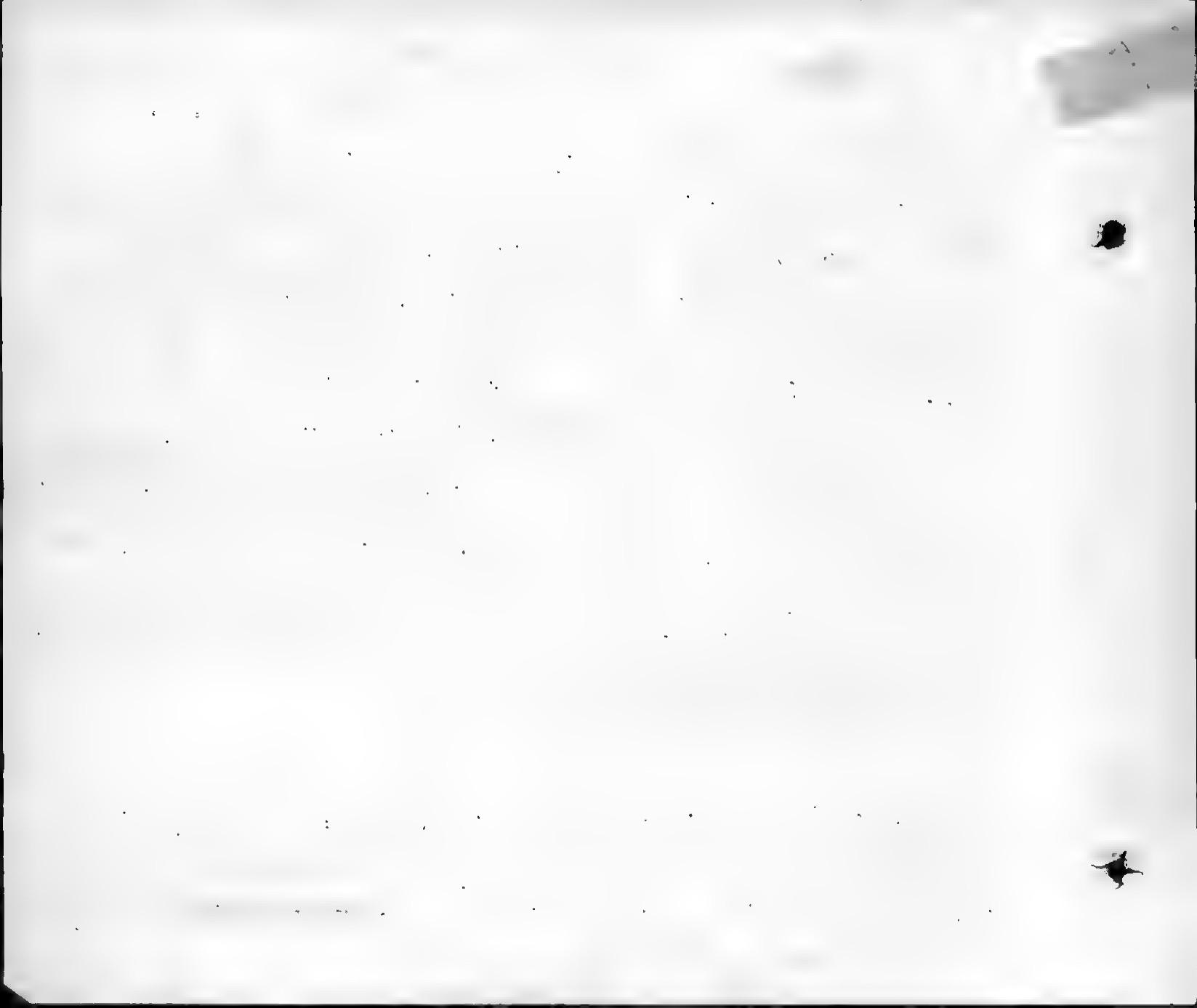
CERTIFICATE OF DEATH

Reg. Dist. No 03206

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		3218 Montgomery Co., MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE		DE. MD		b. COUNTY		Pr. 600.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 17 days.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Mt. Rainier Md.		d. STREET ADDRESS		625 57th Ave. Cap. Ab.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARLEA SANITARIUM				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) FLORA		First P. Middle BEAVERS		4. DATE OF DEATH		Month March		Day 7		Year 1961	
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 21 1885		9. AGE (in years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) WASH. DC.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME WILFORD Nott		14. MOTHER'S MAIDEN NAME AGNES ?									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. UNRIVONAL		INFORMANT EVERETT J. BONNERS SR-625-57-0100 CAREER DR. 100		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Rosebud Valley Accident</i>											
DUE TO <i>baseball player accident</i>											
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generally arteriosclerosis</i>											
DUE TO <i>general arteriosclerosis</i>											
(c)											
INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a), <i>none</i>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>none</i>									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Colmar Manor Park Co., MD.</i>		(County)		(State)	
21. I certify that I attended the deceased from <i>Feb. 20, 1961</i> , to <i>March 7, 1961</i> , that I last saw the deceased alive on <i>March 7, 1961</i> , and that death occurred <i>Mar. 7, 1961</i> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <i>John S. Rogers, M.D.</i> ADDRESS (Street, city or town, state) <i>625 Lengoway St., Silver Spring, Md.</i> DATE SIGNED <i>3-7-61</i>											
PHYSICIAN'S NAME (Type) <i>John S. Rogers</i>											
22a. BURIAL, CREMATION REMOVAL (Specify)		22b. DATE THEREOF 3/11/61		22c. NAME OF CEMETERY OR CREMATORIUM FORT LINCOLN CEM.		22d. LOCATION (City, town, or county) <i>Colmar Manor Park Co., MD.</i>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. H. Chambers, Washington, D.C.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 13 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3219

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1. PLACE OF DEATH
a. COUNTY

Montgomery

b. CITY OR TOWN, if outside corporate limits, write RURAL and give nearest town

Takoma Park

c. LENGTH OF STAY IN TB

1 week

MARYLAND

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington Sanitarium

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Beck

4. SEX

male

6. COLOR OR RACE

Cauc.

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

4. DATE
OF
DEATH

Month

Day

Year

3

5

1961

6-16-60

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Maryland

13. FATHER'S NAME

Robert S. Beck

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.

(Yes, no, or unknown) (If yes give war or date of service)

17. INFORMANT

admission Record

Address

Washington
Sanitarium

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

154 DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Congenital heart disease (Tetralogy of Fallot)

INTERVAL BETWEEN
ONSET AND DEATH

8 months

MEDICAL CERTIFICATION

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Dehydration

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 6/16/61 to 3/5/61, that (I) (we) last saw the deceased alive on 3/5/61, and that death occurred at 12 PM, from the causes and on the date stated above.

22a. SIGNATURE

Rino Magi

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
GNEO

3/6/61

22c. PHYSICIAN'S
NAME (Type)

EINO MAGI

22d. ADDRESS

918 Alvin Blvd. E. Silver Spring, Md.

23a. BURIAL, CREMATION, DATE THEREOF
REMOVAL (Specify)

Burial 3-7-61

23c. NAME OF CEMETERY OR CRÉMATORIUM

Port Lincoln Cemetery

23d. LOCATION (City, town or county)

Rock George County, Md.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE
BY DAY

J. Arthur Waller

ADDRESS

254 CARROLL ST. NW

WASH. 12, D.C.

25e. REC'D BY REGISTRAR

MAR 7 '61

DATE

25f. REGISTRAR'S SIGNATURE

John J. Quinn

VR A15 (4)
15M 6/60

Moors



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician.

11 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03268

3220

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)				
<i>Wheaton Montgomery Maryland</i>		a. STATE <input checked="" type="checkbox"/> Maryland	b. COUNTY <input checked="" type="checkbox"/> Rockville <i>MONTGOMERY</i>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)		c. LENGTH OF STAY IN lb less than 1 month				
<i>Wheaton, Maryland</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <i>129 Talbott St.</i>				
<i>Wheaton Nursing Home</i>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3 NAME OF DECEASED (Type or print)		First <i>HENRY</i>	Middle <i>ALBIN</i>			
4 DATE OF DEATH		Month <i>March</i>	Day <i>19</i>			
5. SEX		6 COLOR OR RACE <i>Male White</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8 DATE OF BIRTH		9 AGE (In years last birthday) <i>75</i> yrs	10 IF UNDER 1 YEAR IF UNDER 24 HRS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>			
10a. USUA. OCCUPATION (Give kind of work done during most of working life even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Tobin Packing Co.</i>	11. BIRTHPLACE (State or foreign country) <i>Germany</i>			
12 CITIZEN OF WHAT COUNTRY?		<i>U.S.A.</i>				
13. FATHER'S NAME		14 MOTHER'S MAIDEN NAME				
<i>FREDERICK BERNHARD</i>		<i>CAROLINE (unknown)</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO <i>78-03-2300</i>	17. INFORMANT <i>Wheaton Nursing Home</i> Address <i>11901 Ga. Ave. Wheaton, Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)						
<i>334X</i> DUE TO <i>Cerebral Arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>4 mos.</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO <i>Hypertension</i> ? YES						
(c) DUE TO <i>Osteoarthritis</i> ? YES						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Prostatic Hypertrophy</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Dee 160</i>	(County) <i>March 19, 1961</i>	(State) <i>MD</i>
21. I certify that (I) (this hospital) attended the deceased from <i>Dec 160</i> to <i>March 19, 1961</i> , that (I) was last seen the deceased alive on <i>March 18, 1961</i> , and that death occurred at <i>3 P.M.</i> from the causes and on the date stated above.						
22a. SIGNATURE <i>Robert A. Hare</i>		M.D. <input type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>3/19/61</i>			
22c. PHYSICIAN'S NAME (Type) <i>Robert A. Hare</i>		22d. ADDRESS <i>7600 Carroll Ave, Tak. PK, Md</i>				
23a. BURIAL, CREMATION REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>3/21/61</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>PROSPECT HILL CEMETERY</i>		23d. LOCATION (City, town or county) <i>WASHINGTON, D.C.</i> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond J. Zelka</i>		ADDRESS <i>SILVER SPRING, MD.</i>		25a. REG'D BY REGISTRAR <i>MAR 23 1961</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	
				DATE		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

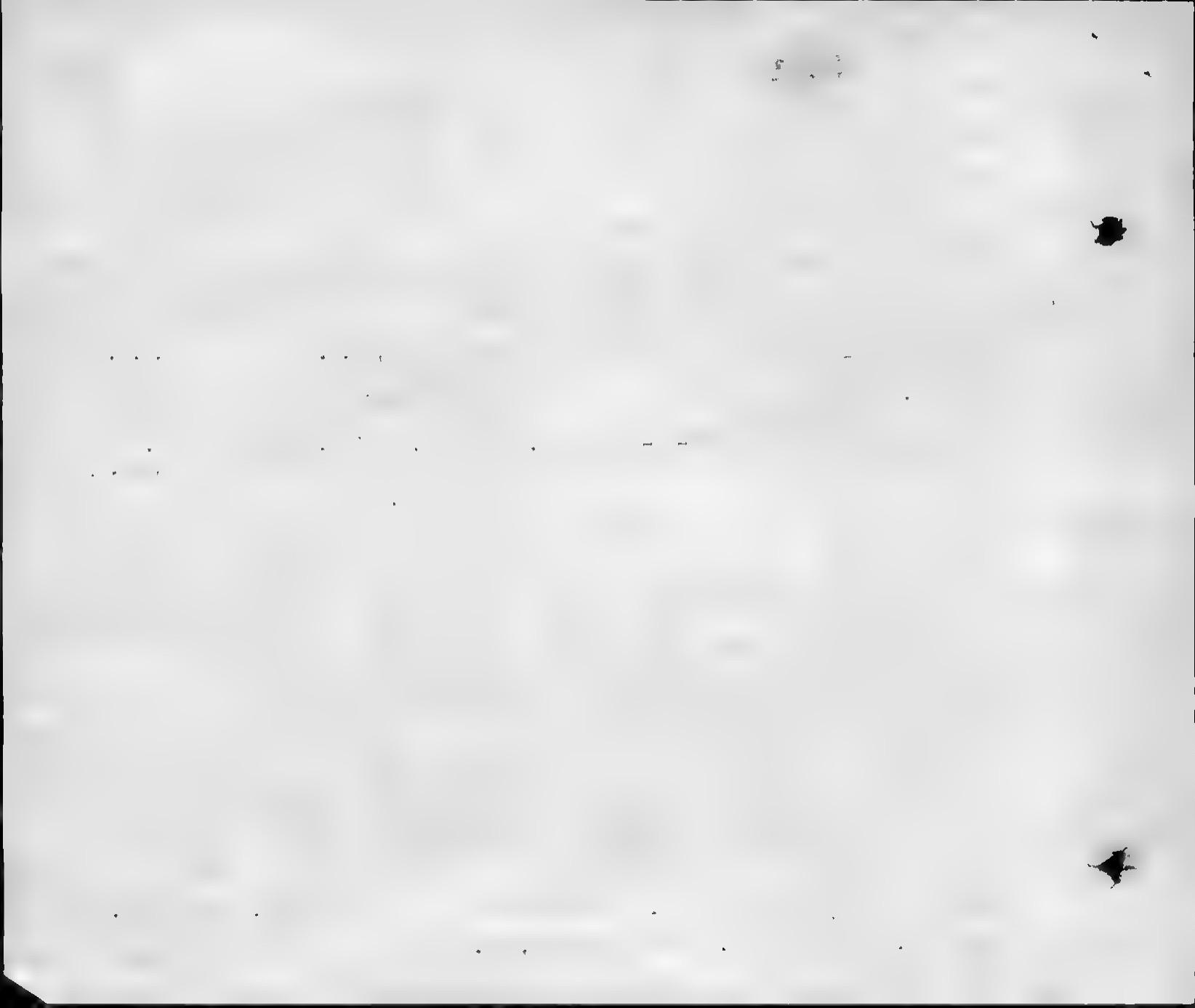
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3221

CERTIFICATE OF DEATH

03209

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE MARYLAND b. COUNTY ANNA ARUNDEL	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 5 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8919 1st Avenue		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EDGEWATER	
3. NAME OF DECEASED (Type or print) RAYMOND HENRY BIRCH		4. DATE OF DEATH March 8 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 6/21/01	9. AGE (In years last birthday) IF UNDER 1 YEAR 59 yrs. Months Days Hours Min. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi driver - own cab		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) WASHINGTON, D.C.	
13. FATHER'S NAME JAMES A. BIRCH		14. MOTHER'S MAIDEN NAME EMMA SPINKS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 17. INFORMANT 579-09-6154 Mrs. Goldie M. Nalley, 8919 1st Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause, etc. DUE TO Carcinoma of pharynx		Address Silver Spring, MD	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) Respiratory failure		INTERVAL BETWEEN ONSET AND DEATH 15 min	
PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) Paroxysm		INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART IV. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) Carcinoma of pharynx		INTERVAL BETWEEN ONSET AND DEATH 6 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (This hospital) attended the deceased from Dec. 1960 to March 8, 1961 , that (I) (we) last saw the deceased alive on Feb. 28 1961 , and that death occurred at 3 PM , from the causes and on the date stated above.		22b. DATE SIGNED March 8, 1961	
22a. SIGNATURE Jules I. Caman		22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) JULES I. CAMAN		22d. ADDRESS 1015 SPRING ST. SILVER SPRING, MD.	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL 3/11/61		23c. NAME OF CEMETERY OR CREMATORIAL FT. LINCOLN CEMETERY	
23b. DATE THEREOF		23d. LOCATION (City, town or county) PRINCE GEO. COUNTY, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUNDELEY, INC.		25a. REC'D BY REGISTRAR DATE MAR 14 '61	
		25b. REGISTRAR'S SIGNATURE Charles E. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached from page 3 and be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3228

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Bethesda

c. LENGTH OF STAY IN 1b
3 M / 16 / 61 9:00 AM
3 / 13 / 61 11:45 PM

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE MD b. COUNTY Montgomery

e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Kensington

f. STREET ADDRESS 13804 - Wexford Dr.

g. IS RESIDENCE ON A FARM? YES NO

3. NAME OF DECEASED (Type or print) Miss Elizabeth B. Bishop

First M Middle I Last Bishop

4. DATE OF DEATH 3 / 13 / 61 Month 3 Day 13 Year 1961

5. SEX F 6. COLOR OR RACE W 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 1 / 7 / 88
WIDOWED DIVORCED

9. AGE (in years last birthday) 73 IF UNDER 1 YEAR Months 2 Days 6 Hours 16 Min. 55
IF UNDER 24 HRS. Hours 16 Min. 55

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (County & State or foreign country)
Halifax Nova Scotia Canada

12. CITIZEN OF WHAT COUNTRY? Canada

13. FATHER'S NAME Frederick W Moore

14. MOTHER'S MAIDEN NAME Jessie Boyd Rhind

15. WAS DECEASED EVER IN U.S. ARMED FORCES? No 16. SOCIAL SECURITY NO. 17. INFORMANT
(Yes, no, or unknown) (If yes give war and dates of service)

17. Address now Thomas N. Sauer

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Shock
DUE TO Carcinoma of sigmoid?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b).
DUE TO Experation
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH 16 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED? YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. Month, Day, Year
p.m. 19

20d. INJURY OCCURRED While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) 311311 (County) MD (State) MD

21. I certify that (I) (this hospital) attended the deceased from 3 / 1 / 61 to 3 / 13 / 61, that (I) (we) last saw the deceased alive on 3 / 13 / 61, and that death occurred at 3 / 13 / 61 M, from the causes and on the date stated above.

22. SIGNATURE A. J. Brennan

22c. PHYSICIAN'S NAME (Type) A. J. Brennan

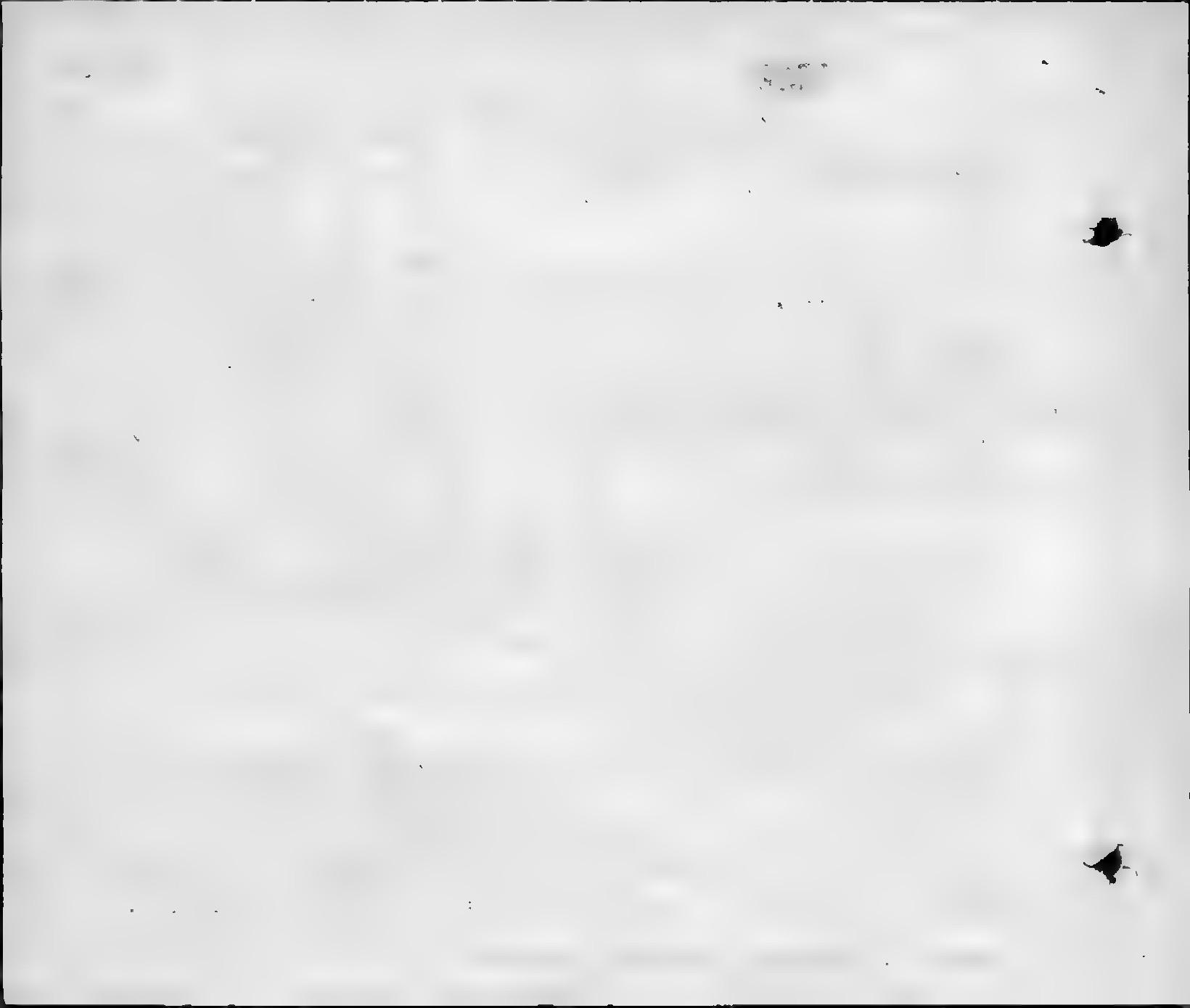
22d. ADDRESS Bethesda, Maryland

22e. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.
M.D. 311311 22f. DATE SIGNED 3 / 13 / 61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 3 / 16 / 61 23c. NAME OF CEMETERY OR CREMATORIES Rock Creek Cemetery 23d. LOCATION (City, town or county) Washington, D. C. (State) DC

24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland

25a. REC'D. BY REGISTRAR MAR 16 61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus DATE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

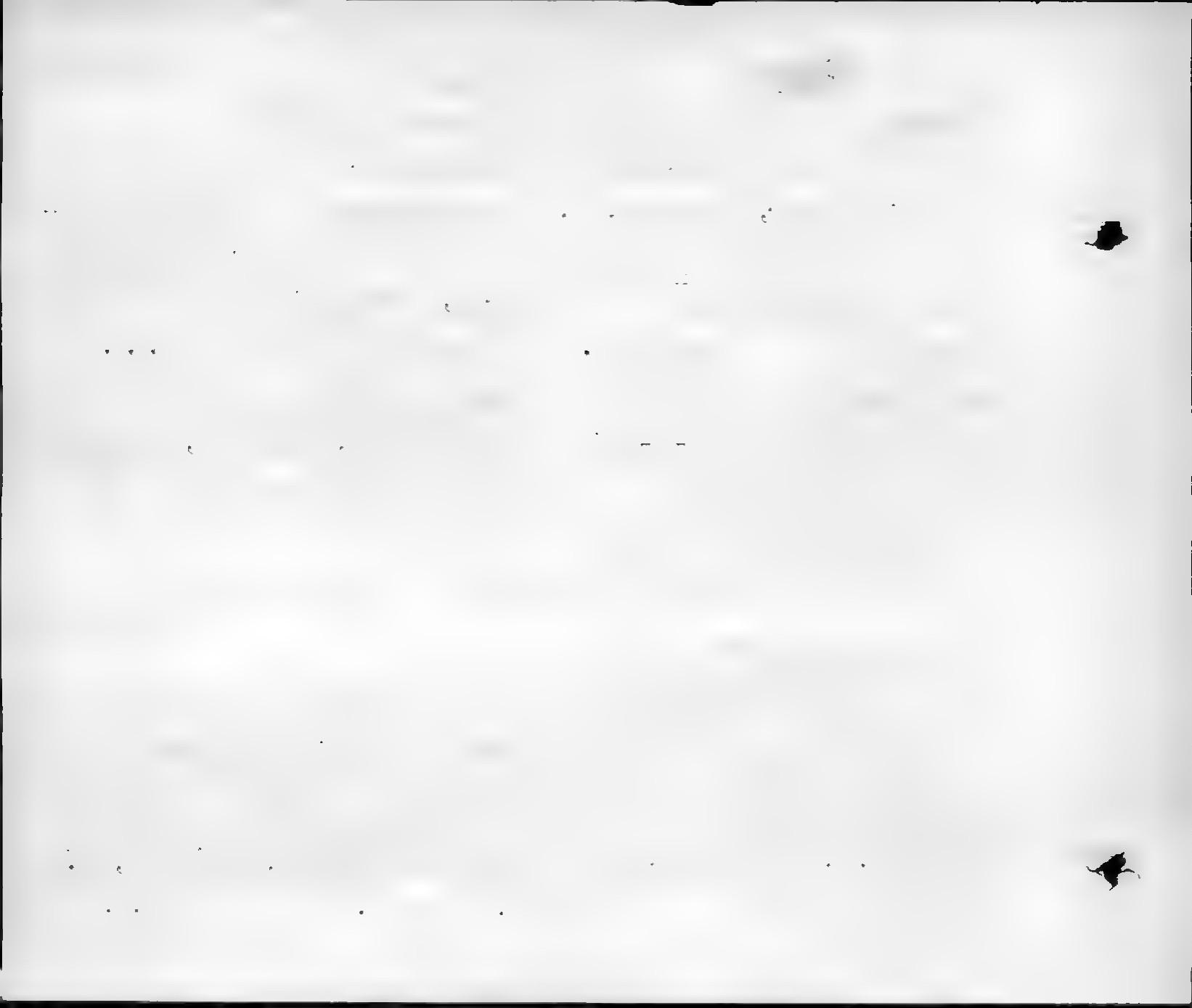
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03211

3223		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE New Jersey b. COUNTY _____								
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Point Pleasant d. STREET ADDRESS 282 Sudbury Road						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		4. DATE OF DEATH Month March Day 7 Year 1961								
3. NAME OF DECEASED (Type or print) Edward		First Edward	Middle (None)	Last Blecker	5. AGE (In years less than birthday) 54 yrs					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH June 9, 1906				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Frameman		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.		11. BIRTHPLACE (State or foreign country) New Jersey		9. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>				
13. FATHER'S NAME Henry Blecker		14. MOTHER'S MAIDEN NAME Frances Hertwig						12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO 139-09-7175		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Cardiac Decompensation, Intra-Operative		19. INTERVAL BETWEEN ONSET AND DEATH 30 Minutes								
411X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		Years								
(b) Severe Aortic Valve Incompetency		Since Childhood								
(c) Rheumatic Heart Disease										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from March 5, 1961 to March 7, 1961 , that (I) (we) last saw the deceased alive on March 7, 1961 , and that death occurred at 12:55 P.M. from the causes and on the date stated above.								22b. DATE SIGNED 3-8-61		
22c. PHYSICIAN'S NAME (Type) J. W. GILBERT, M.D.		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE THEREOF 3/8/61		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Graceland Mem. Park Cem. Kenilworth, N.J.		23d. LOCATION (City, town, or county) (State)				
24. FUNERAL DIRECTOR'S SIGNATURE J. W. G. Gilbert Co.		25a. REC'D BY REGISTRAR DATE MAR 10 1961		25b. REGISTRAR'S SIGNATURE James S. Kraus						



HOSPITAL OR ATTINING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician.
 page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

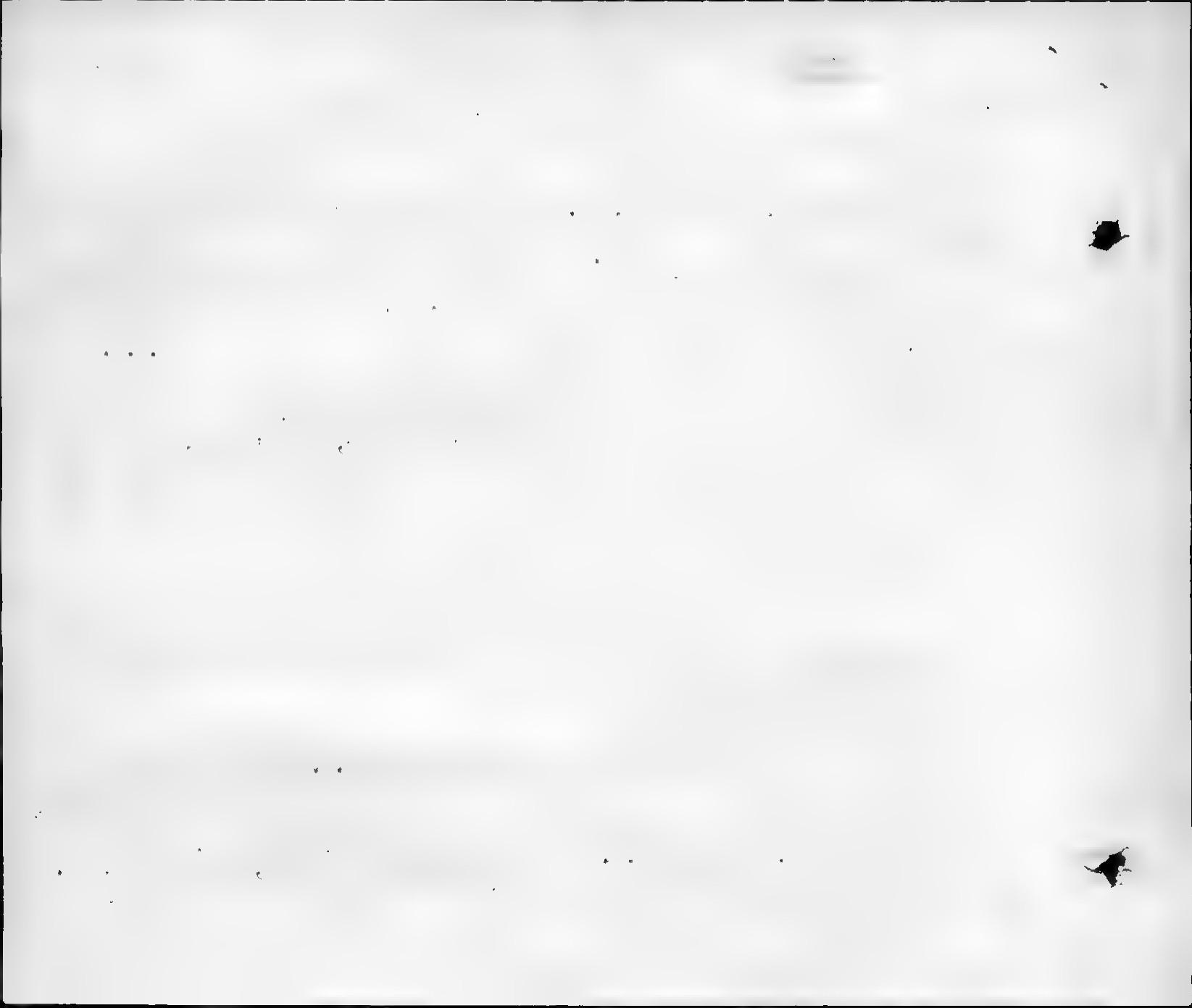
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03212

3224

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 25 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 10550 MacArthur Boulevard		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.								
3. NAME OF DECEASED (Type or print) Charles		First F.	Middle .	Last Bodine	4. DATE OF DEATH March 29, 1879	Month March	Day 12	Year 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH March 29, 1879		9. AGE (In years last birthday) 81	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 81	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Service Station		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph Bodine				14. MOTHER'S MAIDEN NAME Elizabeth Stone				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH 3 months		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Multiple Myeloma						
203X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO						
{		DUE TO						
(c)								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from February 15, 1961 to March 12, 1961 , that (I) (we) last saw the deceased alive on March 12, 1961 , and that death occurred at 12:50 P.M. from the causes and on the date stated above.								
22a. SIGNATURE <i>Robert B. Scoggins</i>		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/13/61				
22c. PHYSICIAN'S NAME (Type) ROBERT B. SCOGGINS, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.						
23a. BURIAL CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF 3/15/61		23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery		23d. LOCATION (City, town or county) (State) Rockville, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE MAR 16 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3225

CERTIFICATE OF DEATH

03213

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

c. LENGTH OF STAY IN lb

MARYLAND

13 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

U. S. Naval Hospital

First
3. NAME OF
DECEASED
(Type or print)

Middle

Charles

Frederick

4. SEX

Male

6. COLOR OR RACE

Caucasian

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

2. USUAL RESIDENCE (Where deceased lived, if institution, Residencia before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

d. STREET ADDRESS

4501 Gretna Street

Res

Month

Day

Year

4. DATE OF DEATH

March 1

1961

9. AGE (In years, est b/rhday) 10. IF UNDER 1 YEAR

79 yrs.

Months

Days

If under 24 hrs.

Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Grain Buyer

10b. KIND OF BUSINESS OR INDUSTRY

Agriculture

11. BIRTHPLACE (County & State, or foreign country)

South Dakota

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Frederick BOHN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and dates of service)

No

16. SOCIAL SECURITY NO

17. INFORMANT

Address

(S) Capt. C.L. Bohn, DC, USN, same as #2 above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

152 DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, or item 18)

20c. TIME OF INJURY Month Day Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (X) (this hospital) attended the deceased from ... Feb. 16, 1961 to March 1, 1961, that (X) (we) last saw the deceased alive on March 1, 1961, and that death occurred at ... M, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

Russell MILLER, JR., LT, MC, USN U. S. Naval Hospital, Bethesda, Md.

23b. BURIAL, CREMATION REMOVAL (Specify)

Burial-Shipment 3-2-61

24. FUNERAL DIRECTOR'S SIGNATURE

Tyson Wheeler

23c. NAME OF CEMETERY OR CREMATORIUM

Frankfort Cemetery

23d. LOCATION (City, town or county)

Frankfort

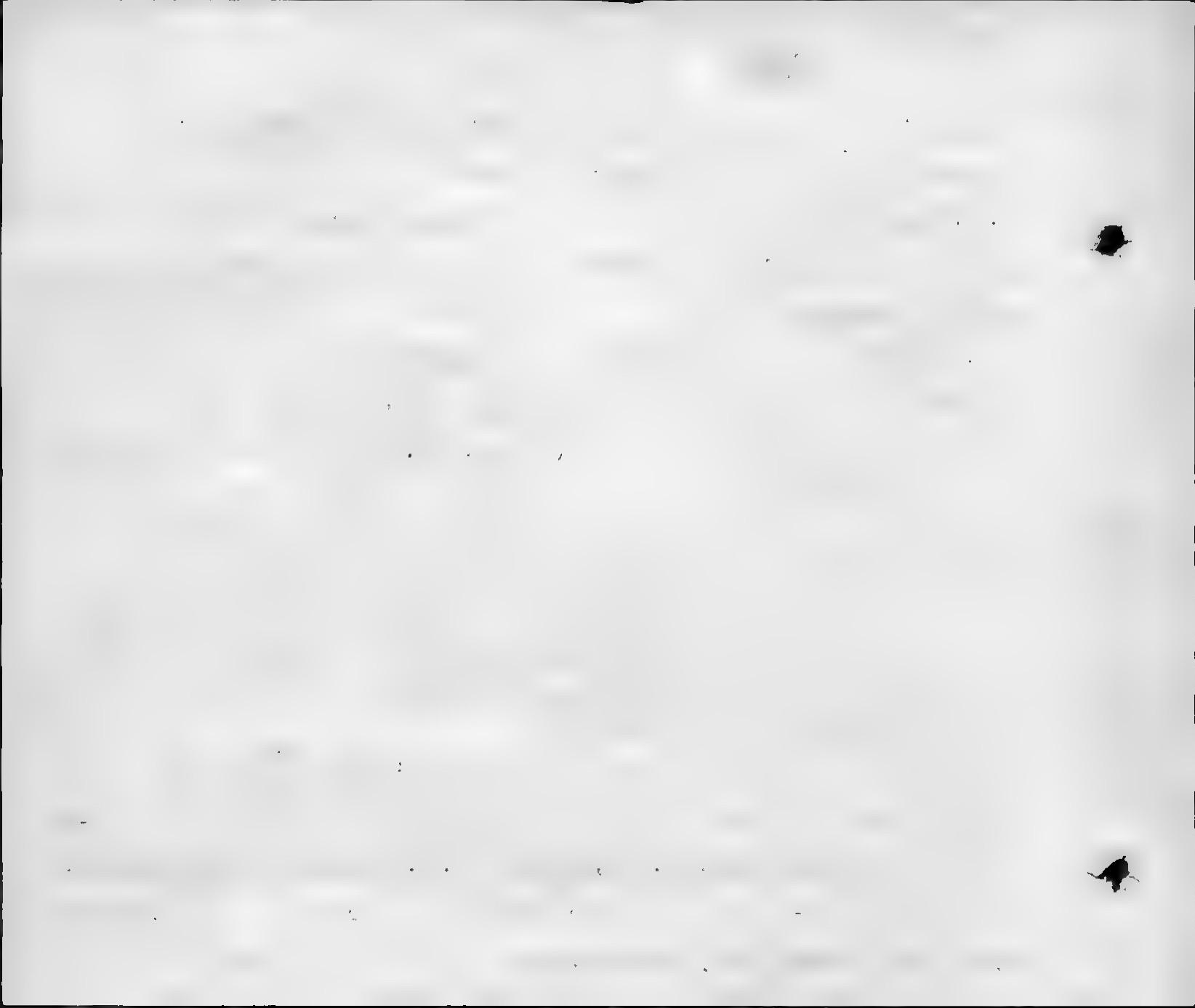
(State)

So. Dakota

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE MAR 3 '61

Arthur S. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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15M 9/60

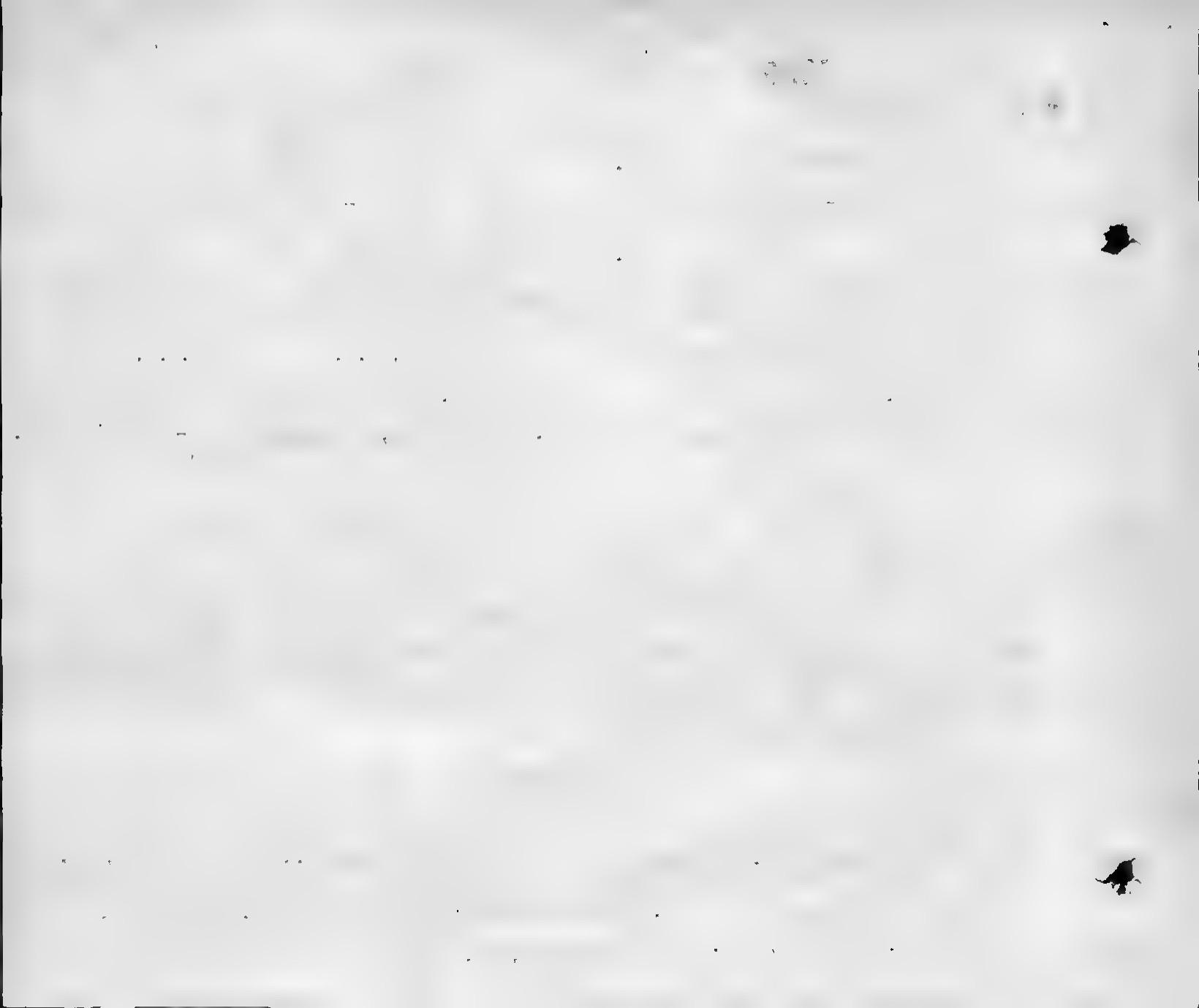
**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

03214

3226

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
MONTGOMERY		a. STATE	MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		b. COUNTY	MONTGOMERY
SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	SILVER SPRING
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1300 COLESVILLE-BELTSVILLE ROAD		d. STREET ADDRESS	1300 COLESVILLE-BELTSVILLE ROAD
3. NAME OF DECEASED (Type or print)		First	Middle
		SARAH	B.
4. DATE OF DEATH		Month	Day
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
FEMALE		WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR 72 yrs
5/28/88		Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		11. BIRTHPLACE (County & State or foreign country) WASHINGTON, D.C.	
13. FATHER'S NAME WILLIAM F. KING		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or grade of serv co) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Bessie King, 1300 Colesville-Beltsville Rd. Silver Spring, Maryland		INTERVAL BETWEEN ONSET AND DEATH 16 yrs 15 yrs 3 yrs	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (b) 443 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. } DUE TO (b) } DUE TO (c) Hypertension Heart Disease Atherosclerosis Generalized Osteoarthritis Hip		Cerebral Thrombosis = partial Right Hemiplegia (7 yrs)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAMED DISEASE CONDITION GIVEN IN PART I (e)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR, CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or part of item 18)		20c. TIME OF INJURY Month, Day Year Hour a.m. 15 3/19 p.m. 1 PM 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.) March	
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1, 1961 to March 1, 1961, that (I) (we) last saw the deceased alive on March 1, 1961, and that death occurred at 8:45 A.M. from the causes and on the date stated above.		22b. DATE SIGNED March 1, 1961	
22a. SIGNATURE Kenneth F. Laughlin		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) KENNETH F. LAUGHLIN		22d. ADDRESS 934 Ellsworth Dr., Silver Spring, Md.	
23b. DATE THEREOF REMOVAL (Specify) BURIAL 3/4/61		23c. NAME OF CEMETERY OR CREMATORIUM FT. LINCOLN CEMETERY	
23d. LOCATION (City, town or county) PRINCE GEO. COUNTY, MD.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Edmund L. Jezka		25a. REC'D BY REGISTRAR MAR 8 '61 DATE	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

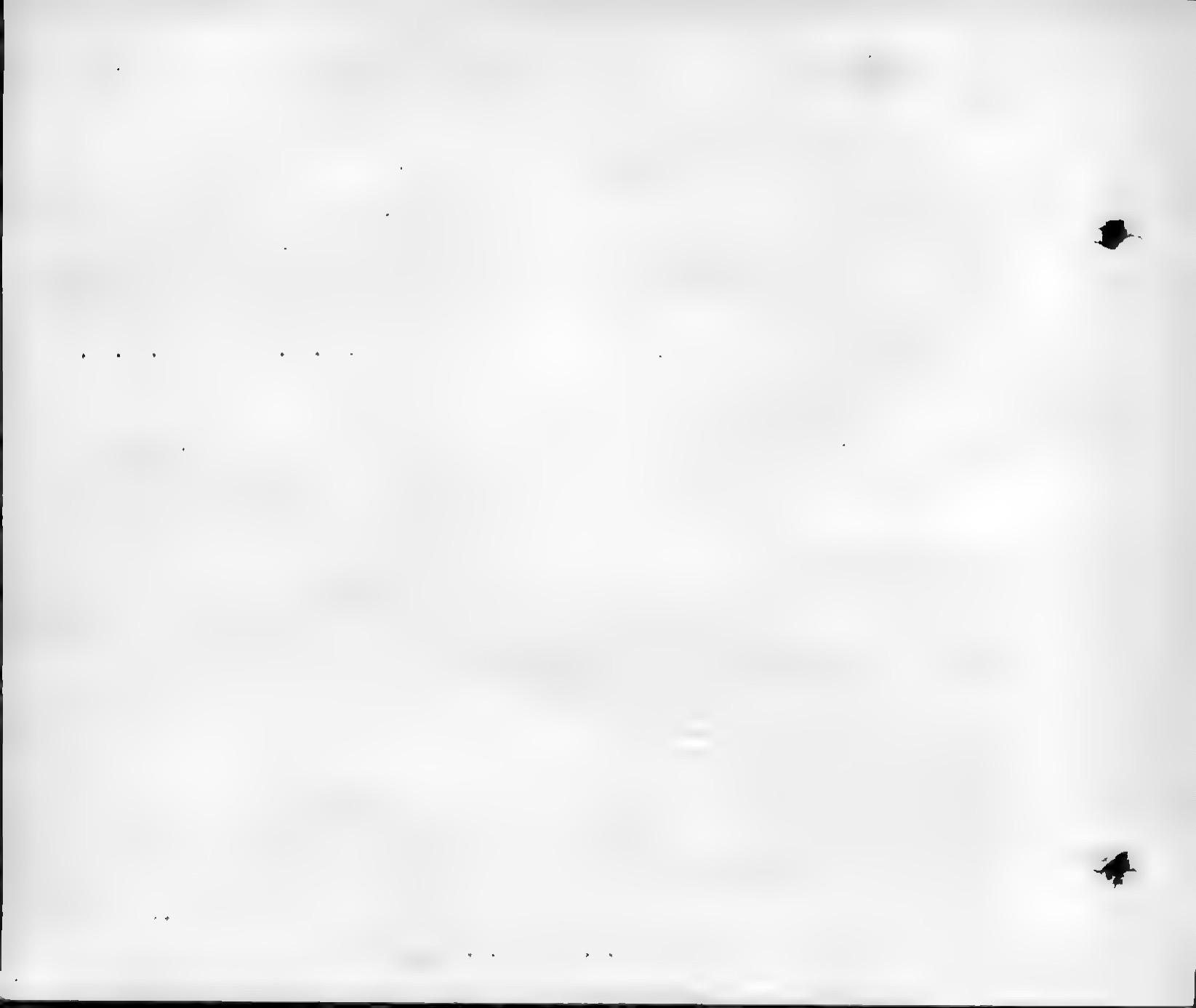
03215

3227

Item 2 Film 600

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges County		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL		c. LENGTH OF STAY IN lb Silver Spring	
		Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8865 Piney Branch Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
f. STREET ADDRESS 8865 Piney Branch Road		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ruth Emma Bratburd		First	Middle
Last		4. DATE OF DEATH March 15, 1961	Month Day Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
		8. DATE OF BIRTH July 18, 1899	9. AGE (In years lost birthday) 61 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Homemaker	11. BIRTHPLACE (State or foreign country) Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Gustave Baumbach	
14. MOTHER'S MAIDEN NAME Virginia		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. Eddie Bratburd		17. INFORMANT 8865 Piney Branch Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 155.1		Terminal Pulmonary Edema 2 days	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b)		Portal Obstruction 10 days	
DUE TO (c)		Carcinoma of Gall Bladder 3 months	
DUE TO		Diabetes Mellitus	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (Francis X. Richardson) attended the deceased from 12/34 , 19 60 to 3/16 , 19 61 , that (I) (Arthur Walters) last saw the deceased alive on 3/14 , 19 61 , and that death occurred at 2:15 P.M. from the causes and on the date stated above.		22b. DATE SIGNED 3/16/61	
22c. PHYSICIAN'S NAME (Type) Francis X. Richardson		22d. ADDRESS 11412 Viers Mill Rd. Wheaton, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 16, 1961	
23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln		23d. LOCATION (City, town, or county) (State) Prince Georges Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur Walters		ADDRESS 254 Carroll St, N.W. Wash, D.C.	
25a. REC'D BY REGISTRAR MAR 16 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Krause	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3228

03216

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY NSVILLE		c. LENGTH OF STAY IN 1b 2 HOURS					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAYTONSVILLE					
3. NAME OF DECEASED (Type or print) CHARLES SYLVESTER BRIGHT		4. DATE OF DEATH MARCH 2, 1961					
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MARCH 2, 1961				
9. AGE (In years last birthday) yrs		10. IF UNDER 1 YEAR Months Days Hours Min					
11. BIRTHPLACE (State or foreign country) MONTGOMERY COUNTY		12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME SHEILA LEE BRIGHT					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.					
17. INFORMANT		Address					
HOSPITAL RECORDS, OLNEY, MARYLAND							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity - 2 lb 12 oz.							
INTERVAL BETWEEN ONSET AND DEATH 2 hr							
76. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Atelectasis of lungs 2 hr							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 3/2 1961 , and that death occurred 3/2 1961 , at 19 R:30 A.M. from the causes and on the date stated above.							
22a SIGNATURE 		M.D. ATTENDING PHYS.		MED DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) C. H. LIGON, M. D.		22d. ADDRESS SANDY SPRING, MARYLAND				22b. DATE SIGNED 3/2/61	
23a BURIAL CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 3/4/61		23c NAME OF CEMETERY OR CREMATORIAL Lincoln P. rk.,		23d LOCATION (City, town or county) Rockville, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS Rockville, Md.		25a REC'D BY REGISTRAR MAR 20 '61		25b REGISTRAR'S SIGNATURE 	



1
FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL DIRECTOR: This certificate should be executed within 24 hours after death. If any delay is necessary, please initial the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3229 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03217

1. PLACE OF DEATH

b. COUNTY

Montgomery

MARYLAND

LENGTH OF STAY IN 1b

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park, Md.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Wash. Sp. & Hosp.

3. NAME OF
DECEASED
(Type or print)

4. SEX

f

6. COLOR OR RACE

W

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

WIDOWED

DIVORCED

Revere

51 Highland ST

Last

DATE
OF
DEATH

Month

Day

Year

3 26 1961

IF UNDER 1 YEAR
Months Days Hours Min.

IF UNDER 24 HRS.

12. CITIZEN OF WHAT COUNTRY?

Romania

Romania

13. FATHER'S NAME

Harry Greenberg

UNKNOWN

Address

Street as
described

INTERVAL BETWEEN
ONSET AND DEATH

1½ hrs

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give award dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

MR. Samuel Brooks

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a).

Conditions, if any, which

gave rise to immediate cause

(a), stating the underlying

cause last.

DUE TO

(b)

DUE TO

(c)

Coronary heart failure

Coronary occlusion

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

DATE SIGNED

3-26-61

22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL

22b. DATE THEREOF
MARCH 28, 1961

22c. NAME OF CEMETERY OR CREMATORIUM
TIFFRETH ISRAEL CEMETERY EVERETT MASS

(State)

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

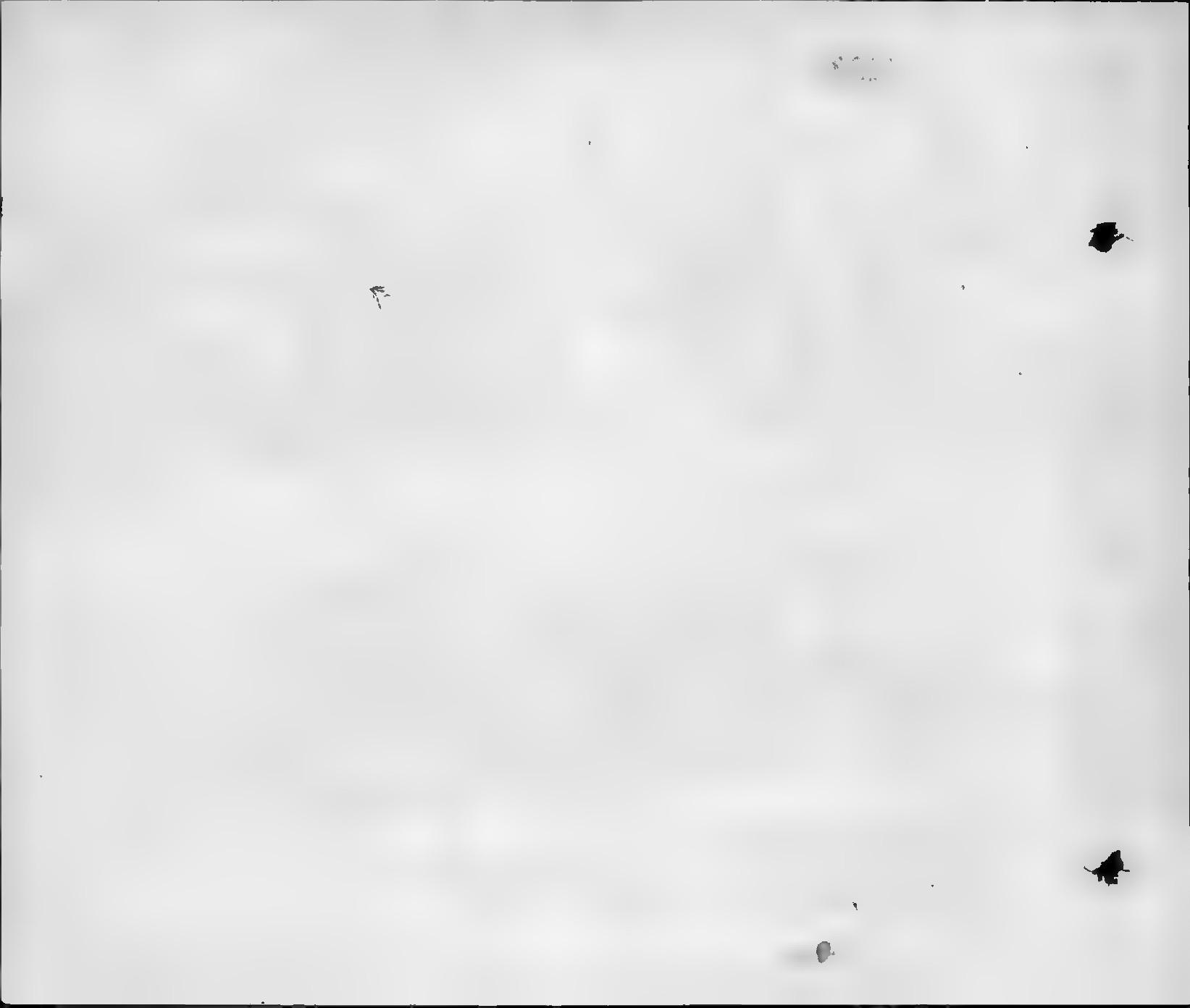
DATE MAR 28 '61

24b. REGISTRAR'S SIGNATURE

B. Broeschert & Sons 3501-1402nd

VS. ATIME
SM 7/59

Curtis S. Kline



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please initial the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
T FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3230 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03218

1. PLACE OF DEATH

a. COUNTY

MONTGOMERY

MARYLAND

c. LENGTH OF STAY IN 1b

2 years

b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town)

SILVER SPRING

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

127 EASTMOOR DRIVE

3. NAME OF
DECEDERED
(Type or print)

First
WILLIAM

Middle
EDWARD

Last
BROOKS

4. DATE
OF
DEATH

Month
MARCH

Day
19
Year
1961

5. SEX

6. COLOR OR RACE

WHITE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

8/1/90

9. AGE (in years
last birthday)

70
yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

Hours

Min.

MALE

WIDOWED

DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Ass't. Cashier (retired)

10b. KIND OF BUSINESS OR INDUSTRY

Riggs Nat'l Bank

11. BIRTHPLACE (State or foreign country)

Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

JAMES E. BROOKS

14. MOTHER'S MAIDEN NAME

MOLLIE WYLIE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give year or dates of service)

NO

16. SOCIAL SECURITY NO., 17. INFORMANT

577-22-1916 Mrs. Margaret M. Brooks, 127 Eastmoor Dr.

Address

Silver Spring, Md.

INTERVAL BETWEEN
ONSET AND DEATH
SUDDEN

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

CORONARY OCCLUSION

201
DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART Ia

19. WAS AUTOPSY PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry and in my opinion
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

CHIEF MEDICAL EXAMINER

ACTUAL
SIGNATURE *Frank J. Broschart*
EXAMINER'S NAME (Type)
NAME (Type) FRANK J. BROSCHEART

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

3/21/61

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,
REMOVAL (Specify)
BURIAL 3/22/61

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

ROCK CREEK CEMETERY

22d. LOCATION (City, town, or country)

WASHINGTON, D.C.

(State)

23. FUNERAL DIRECTOR
R. L. PHIMPHREY, INC.
Raymond J. Ziska

ADDRESS

ST. LUVR. SPRING, MD.

24a. REC'D BY REGISTRAR

MAR 23 '61

DATE

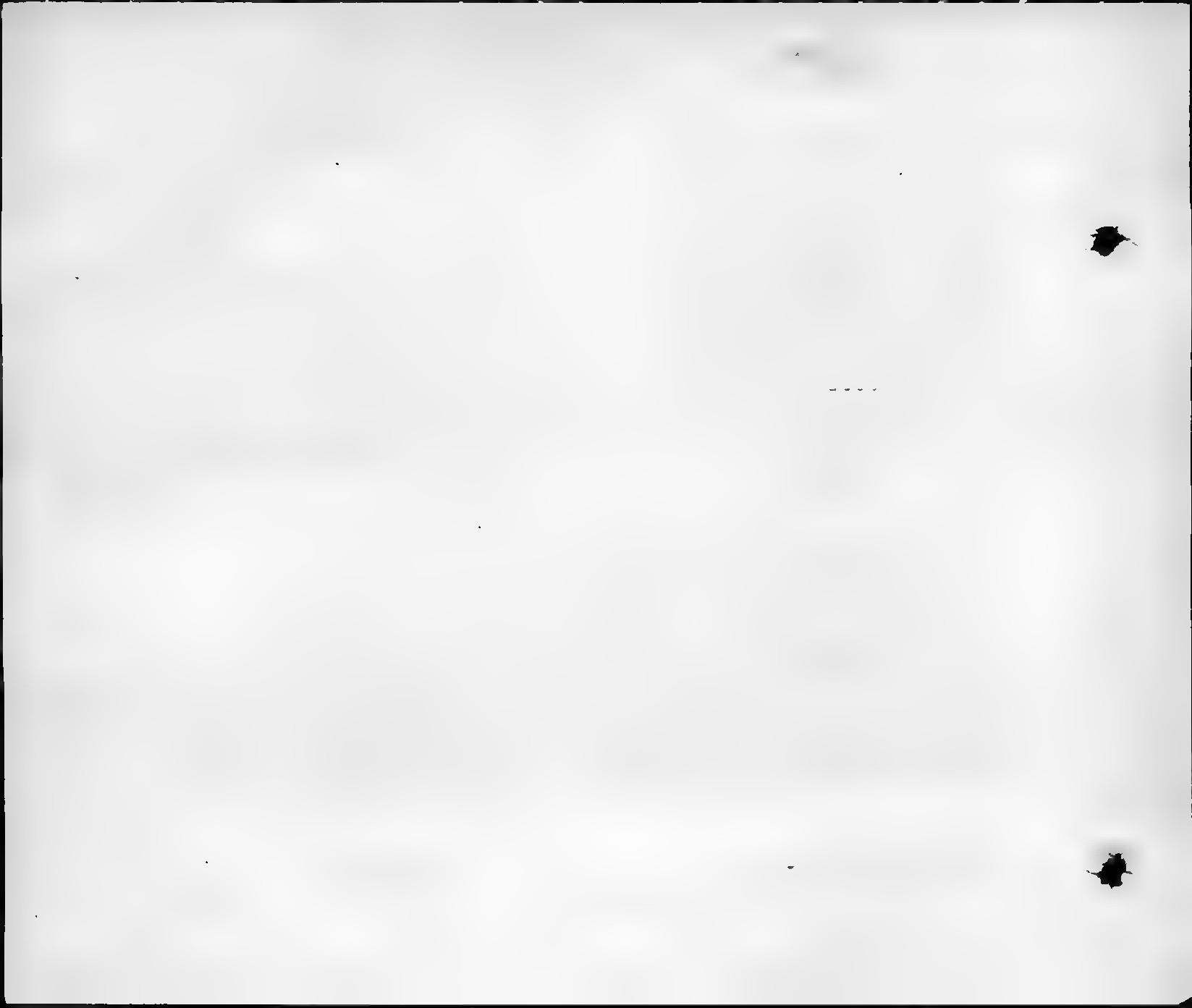
24b. REGISTRAR'S SIGNATURE

Arthur S. Thomas



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 may be retained by the hospital or attending physician.
 This certificate could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND												03219									
3231						CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>						2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Maryland</i>															
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>						c. LENGTH OF STAY IN 1b <i>2 hrs.</i>						b. COUNTY <i>Montgomery</i>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + 1/05</i>						d. STREET ADDRESS <i>3604 Upshur St</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <i>Robert Winfield</i>						First		Middle		Last		4. DATE OF DEATH <i>3</i>	Month	Day	Year						
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8/23/85</i>		9. AGE (In years last birthday) <i>75 yrs.</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired - Government Printing Office</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>D.C.</i>		11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Winfield Scott Brown</i>						14. MOTHER'S MAIDEN NAME <i>Unknown</i>															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>None</i>						16. SOCIAL SECURITY NO						17. INFORMANT <i>wife - Mrs. Caroline Brown - Same Address</i>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>420.1</i>						19. INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>															
DUE TO <i>Myocardial Dystrophy</i>																					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Coronary Thrombosis</i>						DUE TO <i>Congestive heart failure</i>															
(c)																					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. <i>19</i>						20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <i>Mar 22, 1961</i> to <i>Mar 22, 1961</i> , that (I) (we) lost saw the deceased alive on <i>Mar 22, 1961</i> , and that death occurred at <i>7 AM</i> , from the causes and on the date stated above						22b. DATE SIGNED <i>Mar 22, 1961</i>															
22a. SIGNATURE <i>Robert B. Tracy</i>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>															
22c. PHYSICIAN'S NAME (Type) <i>Robert B. Tracy</i>						22d. ADDRESS <i>7103 River Rd. Huntsville, Md.</i>															
23a. BUR. A. CREMATION, REMOVAL (Specify) <i>Burial</i>						23b. DATE THEREOF <i>3/25/61</i>						23c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington Fort Lincoln</i>						23d. LOCATION (City, town, or county) <i>Colmar Manor, Md.</i>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Nally Funeral Home Inc.</i>						25a. ADDRESS <i>111 Fairview Rd.</i>						25b. REC'D BY REGISTRAR DATE <i>MAR 28 '61</i>						25b. REGISTRAR'S SIGNATURE <i>Albert S. Kline</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3232

113220

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)	
Montgomery MARYLAND		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookside 4 days		b. COUNTY Mont.	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookside 15 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Luke's Hospital		d. STREET ADDRESS 17 F. St., #3 - Watkins Mill	
3. NAME OF DECEASED (Type or print) Maggie Jane Campbell		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
First Middle Last		f. DATE OF DEATH Month Day Year March 30 1961	
5. SEX Female		g. AGE (In years if under 1 year last birthday) Months Days Hours Min. 79 yrs.	
6. COLOR OR RACE Colored		h. IF UNDER 1 YEAR Months Days Hours Min.	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		i. IF UNDER 24 HRS. Months Days Hours Min.	
WIDOWED <input checked="" type="checkbox"/>		j. 10. LSLAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Cook domestic	
DIVORCED <input type="checkbox"/>		k. 10b. KIND OF BUSINESS OR INDUSTRY	
		l. BIRTHPLACE (County & State, or foreign country) Maryland	
		m. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Washington		n. 14. MOTHER'S MAIDEN NAME Georgina Long	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		o. 16. SOCIAL SECURITY NO. 380-20-0000	
(Yes, no, or unknown) (If yes, give name and date of service)		p. 17. INFORMANT Name: Ella Coffatt - Bel Air, Md.	
q. 18. CAUSE OF DEATH (Enter only one cause per line for a, (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Conditions, if any, which give rise to immediate cause (a), stating the underlying cause first. } DUE TO (b) DUE TO (c) Hypercardiac resufficiency, acute Hyperkinetic cardiovascular renal disease		r. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 14 days 3 years.	
s. 20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. TIME OF INJURY Month, Day, Year Hour a.m. While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> p.m. 19		20c. INJURY OCCURRED 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from... 3/26/61 to 3/30/61, 19..., that (1) (we) last saw the deceased alive on... 3/30/61 19..., and that death occurred at 7 P.M. from the causes and on the date stated above.		22. SIGNATURE Robert N. Coale	
22c. PHYSICIAN'S NAME (Type) ROBERT N. COALE		22d. ADDRESS 4630 Montgomery Ave., Bel Air, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-3-61	
23c. NAME OF CEMETERY OR CREMATORIUM Brooke Grove		23d. LOCATION (City, town or county) Layfayette, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden Rockville Md.		25a. REC'D BY REGISTRAR APR 7 '61	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon part. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon part. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

3233

CERTIFICATE OF DEATH

03221

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN 1b.
3 days

d. NAME OF HOSPITAL OR INSTITUTION, if not in hospital, give street address.

Su burban

First

Middle

Last

4. DATE OF DEATH

March 16 1961

Month Day Year

5. SEX

6. COLOR OR RACE

Male white

7. MARRIED NEVER MARRIED 8. DATE OF BIRTH

WIDOWED DIVORCED

12/17/05

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

School bus driver Board of Education

10b. KIND OF BUSINESS OR INDUSTRY

Board of Education

11. BIRTHPLACE (County & State, or foreign country)

Md. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Elsie Carter

14. MOTHER'S MAIDEN NAME

Minnie Carter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

Yes Unknown

17. INFORMANT

Pearl L. Carter / wife

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Coronary Thrombosis

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b)

DUE TO

(c)

Essential Hypertension

Coronary Artery Disease

INTERVAL BETWEEN ONSET AND DEATH

6 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Diabetes mellitus

19. WAS AUTOPSY PERFORMED?

YES NO

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED

While at work Not While at work

MD

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

310 W. Montgomery Ave, Rockville, Md.

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

Dec. 13, 1960

to *March 16 1961*, that (I) (we) last

saw the deceased alive on *March 16 1961*, and that death occurred *2:45 P.M.* from the causes and on the date stated above.

22a. SIGNATURE

Gordon S. Rosenberger

M.D.

22b. DATE SIGNED

17 Mar 1961

22c. PHYSICIAN'S NAME (Type)

Gordon S. Rosenberger, M. D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22d. ADDRESS

310 W. Montgomery Ave, Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

3/18/61

23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS

Darnestown Cemetery

23d. LOCATION (City, town or county)

Darnestown, Maryland

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Robert A. Pumphrey

Bethesda, Maryland

ADDRESS

310 W. Montgomery Ave, Rockville, Md.

25a. REC'D BY REGISTRAR

Arthur S. Krause

DATE

MAR 20 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Krause

DATE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 & 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3234

CERTIFICATE OF DEATH

03222

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b RURAL and give nearest town TAKOMA PARK 17	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6612 ALLEGHENY AVE.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS 6612 ALLEGHENY AVE 1	
3. NAME OF DECEASED (Type or print) WILLIAM F. CARTER		4. DATE OF DEATH MARCH 26, 1961	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
S SEX M	6 COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 8, 1887
9. AGE (In years last birthday) 74 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUILDER		10b. KIND OF BUSINESS OR INDUSTRY GEN. BLDG TRADES	
11. BIRTHPLACE (State or foreign country) BALTIMORE COUNTY, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Devis Carter		14. MOTHER'S MAIDEN NAME LILLIE FORD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. LOTTIE C. CARTER, 6612 ALLEGHENY AVE.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Caecum of the right lung	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Chronic bronchitis & emphysema	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Apartment bldg. to tract 26-19-61		20f. (City or town) (County) (State) GLEN GLEN, MONTGOMERY, MD.	
21. I certify that (I) (this hospital) attended the deceased from April 24, 1961 to March 26, 1961 that (I) (we) last saw the deceased alive on April 24, 1961 and that death occurred at 7:30 PM , from the causes and on the date stated above.		22a. SIGNATURE Jason Geiger	
22c. PHYSICIAN'S NAME (Type) JASON GEIGER, M.D.		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 3-26-61
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF MAR. 29, 1961	
23c. NAME OF CEMETERY OR CREMATORIAL ST. JOHNS CHURCH CEMETERY FOREST GLEN, MONTGOMERY, MD.		23d. LOCATION (City, town, or county) (State) GLEN GLEN, MONTGOMERY, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur Waller 254 CARROLL ST. N.W.		ADDRESS CLASH, D.C.	25a. REC'D BY REGISTRAR DATE MAR 29 '61
			25b. REGISTRAR'S SIGNATURE John S. Kinsella



FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please initial the certificate, writing the word "pending" in pencil in Item 18. File Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3235 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

103223

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN IB

MARYLAND

6 mo

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Roxane Nursing Home

3. NAME OF
DECEASED
(Type or print)

First

Middle

Casey

4. SEX

femail white

6. COLOR QR RAC

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

18-18-1882

4. DATE
OF
DEATH

Mar

27

1961

Month

Day

Year

10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

HOUSEWIFE

11. BIRTHPLACE (State or foreign country)

SUGAR NOTCH, PENNA.

12. CITIZEN OF WHAT COUNTRY?

XXXXXX XXXXXX XXXX

U.S.A.

13. FATHER'S NAME

John McNamee

14. MOTHER'S MAIDEN NAME

Mary Tracy

Address

Nursing Home Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If yes give rank or date of service)

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

IN 4-7 DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Bronchitis pneumonia

Fractional lung

INTERVAL BETWEEN
ONSET AND DEATH

3 days

19. WAS AUTOPSY PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

fall to floor in Nursing Home

20c. TIME OF INJURY Month, Day, Year
Hour & m.

20d. INJURY OCCURRED Month, Day, Year
Hour & m.

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(County)

(State)

at work at work

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion

death resulted from: Natural causes

Accident

Suicide

Homicide

Undetermined manner

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

DATE SIGNED

Mar 27 - 1961

(State)

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

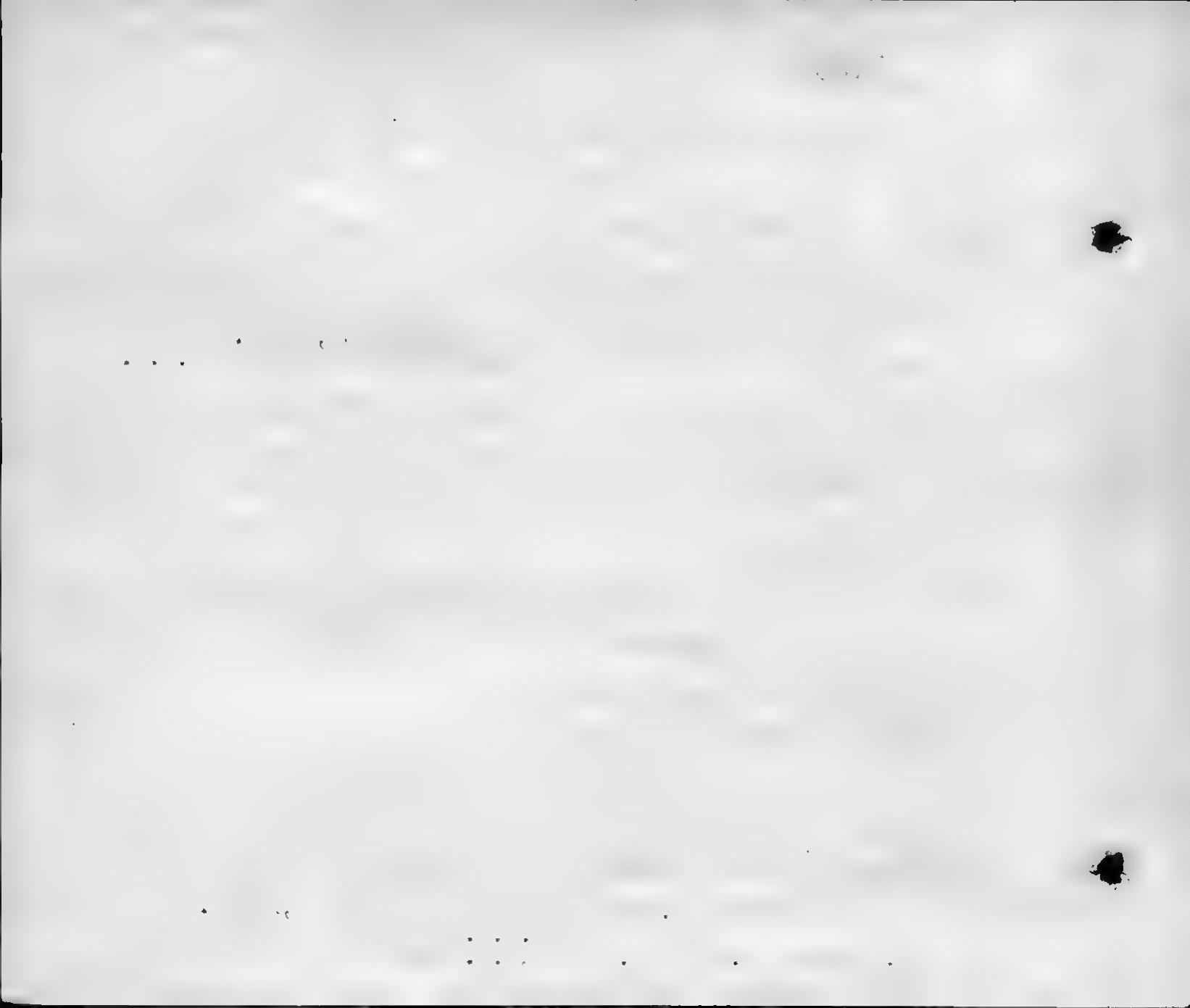
22d. LOCATION (City, town, or country)

(State)

ASHLEY, PENNA.

ASHLLEY, PENNA.

ASHLEY, PENNA.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. **Form 4** may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-hands permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3236

CERTIFICATE OF DEATH

03224

Item 12 Film G285 1/17/67

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Kensington, Md.

c. LENGTH OF STAY IN 1B

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Kensington Nursing Gardens

3. NAME OF
DECEASED
(Type or print)

First
May

Middle
T.

Cerceo

4. SEX

Female

White

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

WIDOWED

DIVORCED

Sept. 2-1874

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Italy

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

George Yasaelli

14. MOTHER'S MAIDEN NAME

Erminia Falcone

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Mrs Josephine Grove-Daughter

110-E. Street N.W.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Congestive Heart Failure
Arteriosclerosis - Hypertension
Senility

INTERVAL BETWEEN
ONSET AND DEATH
2-3 week

yrs

yrs

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY

Month, Day, Year

20d. INJURY OCCURRED

While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(County) (State)

20f. (City or town)

Hour
a.m.
p.m.

19

21. I certify that (I) (this hospital) attended the deceased from [REDACTED] to [REDACTED] that (I) (We) last saw the deceased alive on [REDACTED] and that death occurred at [REDACTED] M. from the causes and on the date stated above.

22a. SIGNATURE

SAM ALLEN, M.D.
NAME (Type)

23a. BUR. AL. [REDACTED]
REMOVALS [REDACTED]

23b. DATE THIRTY
3/18/61

23c. NAME OF CEMETERY OR CREMATORIAL

Mt Olivet Cem.

23d. LOCATION (City, town or county)

Washington, D.C.

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

J. Wm. Lee's Sons Co.

ADDRESS

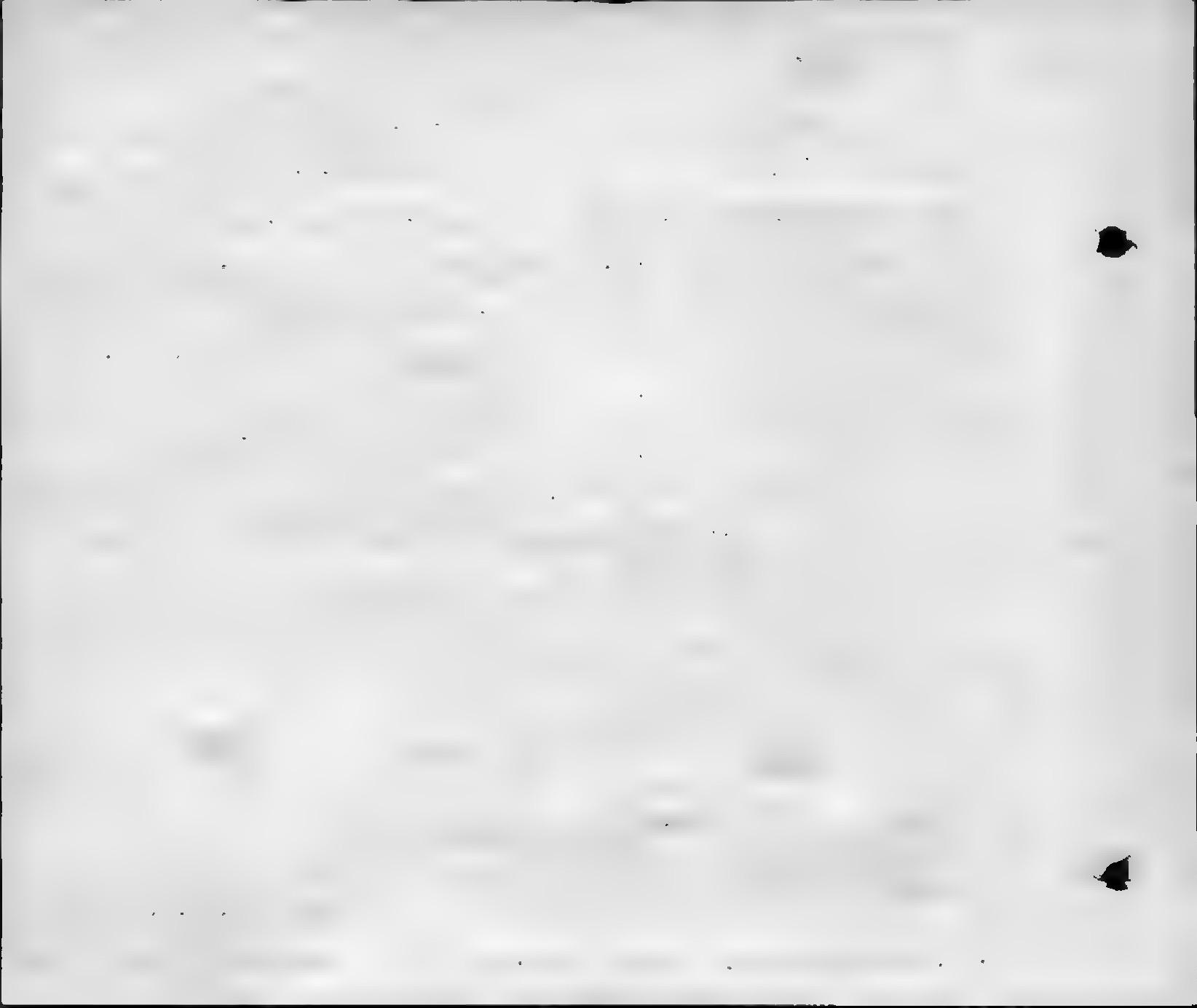
300-4th St. N.E.

25a. REC'D BY REGISTRAR

MAR 17 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Thomas



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

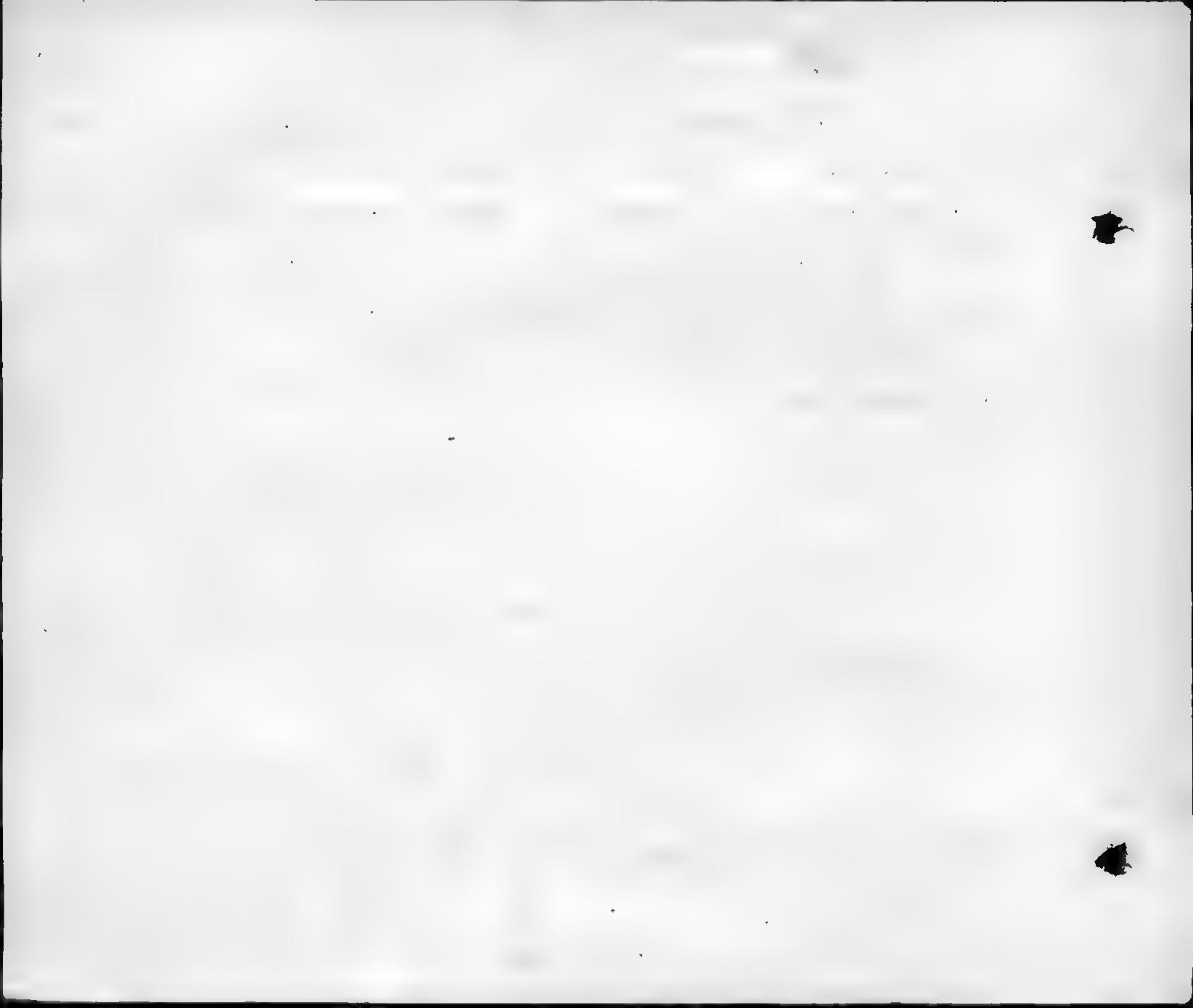
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3, to be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3237 (03225)

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE MARYLAND MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 12 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4408-WALSH STREET		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA, MD	
3. NAME OF DECEASED (Type or print) LAURA TENNANT CHUBB		4. DATE OF DEATH MARCH 24 1961	
S SEX FEMALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH JULY 18, 1871
10a. JSJAI OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE	10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) WISCONSIN	9. AGE (in years last birthday) 89 yrs
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOEL M. TENNANT	
14. MOTHER'S MAIDEN NAME ELLA ADEL DICKERSON		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No) No	
16. SOCIAL SECURITY NO. —		17. INFORMANT MRS. ERNESTINE QUINN - 4408 WALSH ST.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X		INTERVAL BETWEEN ONSET AND DEATH months	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Hypertensive Cardio Vascular Disease		(c) DUE TO 20 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 24, 1961 , that (I) (we) last saw the deceased alive on 3/23/61 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Wm Fleet Luckett		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS 5000 Reservoir Rd. NW DC	22b. DATE SIGNED 3-24-61
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 3-24-1961	23c. NAME OF CEMETERY OR CREMATORIAL CEDAR HILL CEMETERY
24. FUNERAL DIRECTOR'S SIGNATURE H. Don. DeVol		D.C. ADDRESS 2224-Wis. Ave. N.W.	23d. LOCATION (City, town, or county) Washington, D.C.
		D.C. ADDRESS 2224-Wis. Ave. N.W.	25a. REC'D BY REGISTRAR DMAR 27 '61
			25b. REGISTRAR'S SIGNATURE Arthur S. Krause



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 03286

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring,		c. LENGTH OF STAY IN 1b 25 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring, Maryland	
f. STREET ADDRESS Brooke Rd		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles H. Claggett		First	Middle
4. DATE OF DEATH March 14 1961	Month	Day	Year
5. SEX male	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 6 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Marshall Claggett		14. MOTHER'S MAIDEN NAME Leanna Wallace	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Alice E. Claggett		Address Brooke Road, Sandy Spring, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 260X Cardiorespiratory Disease with Edema		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis			
DUE TO (c) Diabetes Mellitus			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bubobocele. Bronchial Asthma. Auricular Fibrillation.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 25 1958 to March 15 1961 , that I last saw the deceased alive on March 14 1961 , and that death occurred at 1:12A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Webster Sewell PHYSICIAN'S NAME (Type) Webster Sewell M.D. Norbeck Rd. 1 Silver Spring, MD DATE SIGNED 3/17/61		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/18/61	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Ash Memorial Cemetery
22d. LOCATION (City, town, or county) Sandy Spring, MD		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swanson		24a. REC'D BY REGISTRAR DATE Mar 23 '61	24b. REGISTRAR'S SIGNATURE Charles S. Mann

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Page 2 and 7 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3239

Item 2 Film G-64

CERTIFICATE OF DEATH

4/12/61 1WK

113227

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if out of corporate limits write RURAL and give nearest town)

Rockville

c. LENGTH OF STAY IN 1b

4/11/61

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington Sanitarium & Hosp

3. NAME OF
DECEASED
(Type or print)

First

Middle

Clemmer

4. SEX

FEMALE white

6. COLOR OR RACE

10a. US. OCCUPATION (Give kind of work done during most of working life, even if retired)

REGISTERED NURSE

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

4/12/12

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Oklahoma

13. FATHER'S NAME

William Howard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO.

20 554-22-1496

17. INFORMANT

P & Hosp, tsi record

18. CAUSE OF DEATH

Acute myocardial infarction

INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Arteric aneurysm

4d.

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)
(County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-21-1961 to 3-25-1961, that (I) (we) last saw the deceased alive on 3-24-1961, and that death occurred at 7:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Abraham W Danish

M.D.

ATTENDING PHYS.

MED. DIRECTOR

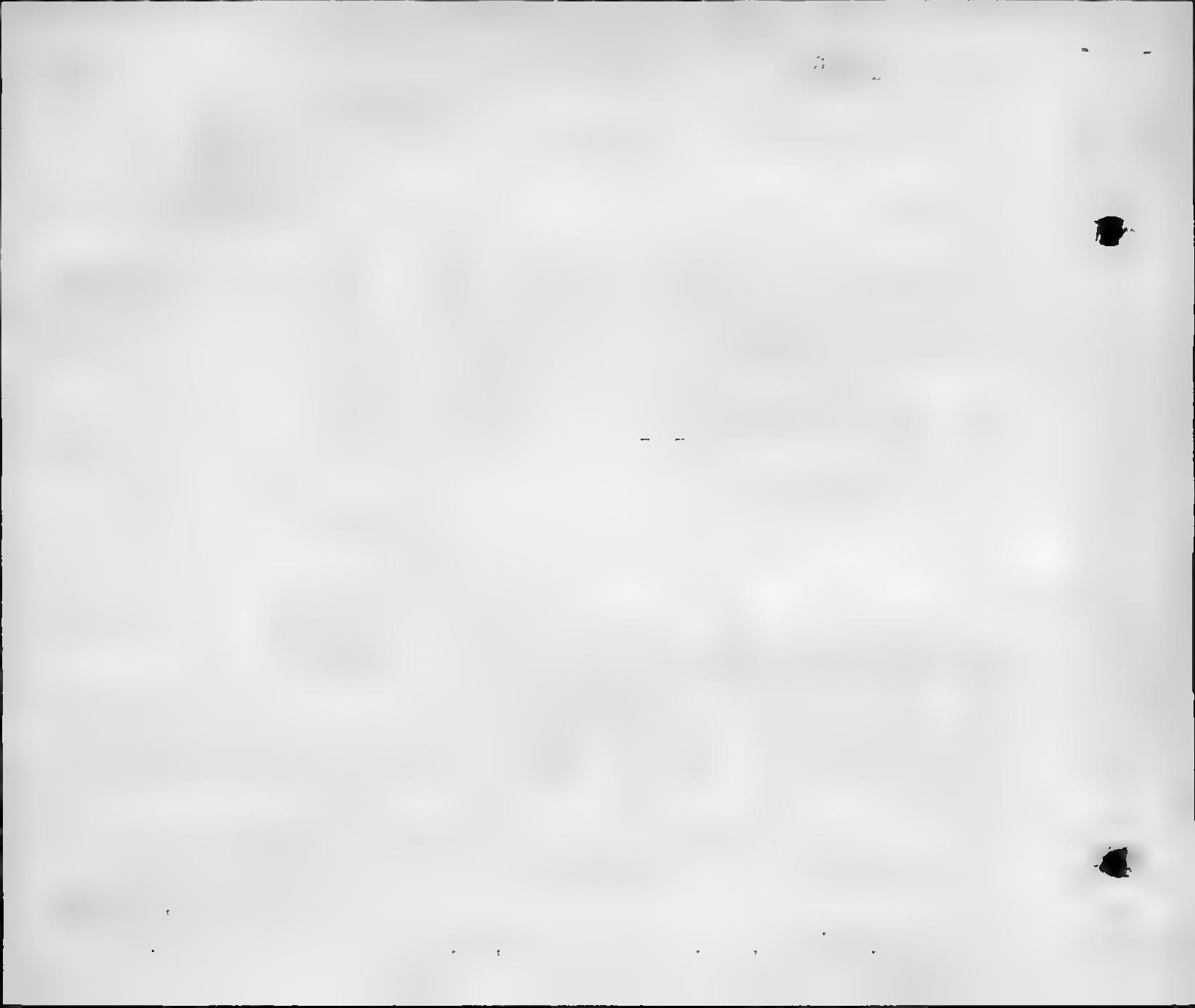
STAFF PHYS.

22b. DATE SIGNED
3-25-6123a. BURIAL, CREMATION, REMOVAL (Specify)
BRIAL 3/29/6123c. NAME OF CEMETERY OR CREMATORIUM
PAIKLAWN CEMETERY23d. LOCATION (City, town or county)
MONTGOMERY COUNTY, MARYLAND
(State)24 FUNERAL DIRECTOR'S SIGNATURE
RIVER E. PUMPHREY INC.ADDRESS
SILVER SPRING, MD.25a. REC'D BY REGISTRAR
DATE 3-29-6125b. REGISTRAR'S SIGNATURE
Celia S. Davis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician, if filled in by the funeral director. After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2240

03228

1. PLACE OF DEATH

b. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

U. S. Naval Hospital

**3. NAME OF DECEASED
(Type or print)**

First

Middle

Calvin

Hayes

5. SEX

6. COLOR OR RACE

Male

Caucasian

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Officer

13. FATHER'S NAME

George W. Cobb

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or date of service)

Yes

16. SOCIAL SECURITY NO. 17. INFORMANT

1907 to 1946

220-34-3661 Hospital Records

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Chevy Chase

d. STREET ADDRESS

5808 Cedar Parkway

Last

4

DATE
OF
DEATH

Month

Day

Year

March 29 1961

9. AGE (In years last birthday)

F UNDER 1 YEAR

Months Days

F UNDER 24 HRS.
Hours Min

71 yrs.

12. CITIZEN OF WHAT COUNTRY?

USA

I

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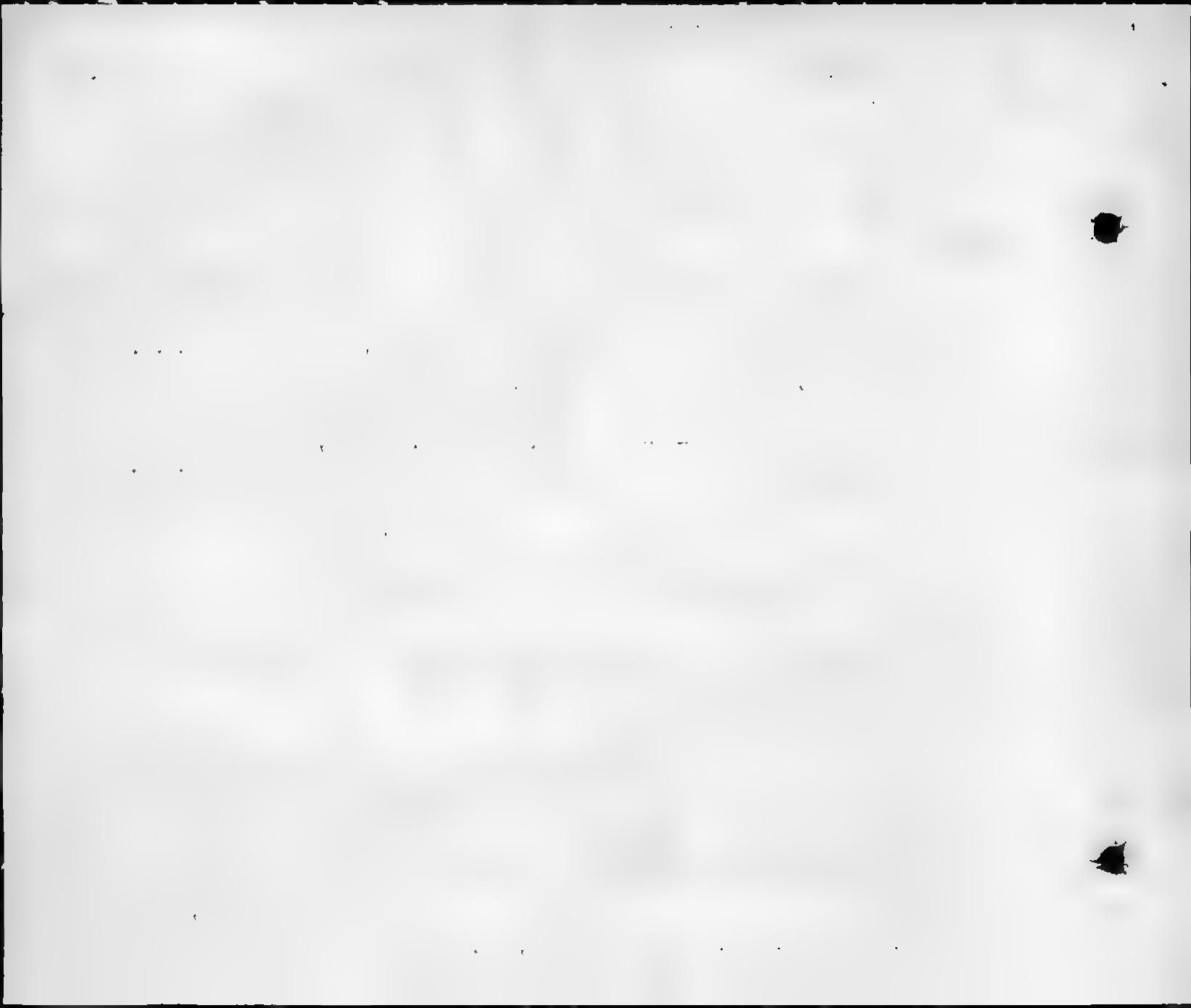
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3241

CERTIFICATE OF DEATH

Reg. Dist. No. 13223

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS NURSING HOME	e. STREET ADDRESS 3710 NIMITZ ROAD	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE	First MIDDLE LYLE	Last COINER	4. DATE OF DEATH MARCH 14 19 61
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/29/82
9. AGE (in years from birthday) 78 yrs		10. IF UNDER 1 YEAR Months Dots Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Express Clerk		10b. KIND OF BUSINESS OR INDUSTRY Seaboard Airline RR	11. BIRTHPLACE (State or foreign country) Waynesboro, Virginia
13. FATHER'S NAME George Casper Coiner		14. MOTHER'S MAIDEN NAME Hannah Rebecca Coiner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 714-16-3346	17. INFORMANT Mrs. Carrie L. Coiner, 9202 Sudbury Road
Address Silver Spring, INTERNAL BETWEEN ONSET AND DEATH +2 weeks			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>George Casper Coiner</i> DUE TO <i>Heart Failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Arteriosclerosis</i> DUE TO <i>Senile</i> (c) <i>Senile</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>3/1/61</i> , 19 <i>61</i> , to <i>3/1/61</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>3/1/61</i> , 19 <i>61</i> , and that death occurred at <i>11:22 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>SAM Allen M.D.</i>		ADDRESS (Street, city or town, state) <i>Kensington, Maryland</i> DATE SIGNED <i>SAM Allen, M.D.</i>	
22a. BURIAL CREMATION, DATE THEREOF REMOVAL (Specify) BURIAL 3/18/61		22c. NAME OF CEMETERY OR CREMATORIUM PARKLAWN CEMETERY	
22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND			
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. <i>Raymond L. Ziska</i>		24a. REC'D BY REGISTRAR DATE MAR 20 '61	
24b. REGISTRAR'S SIGNATURE <i>Charles S. Knarr</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

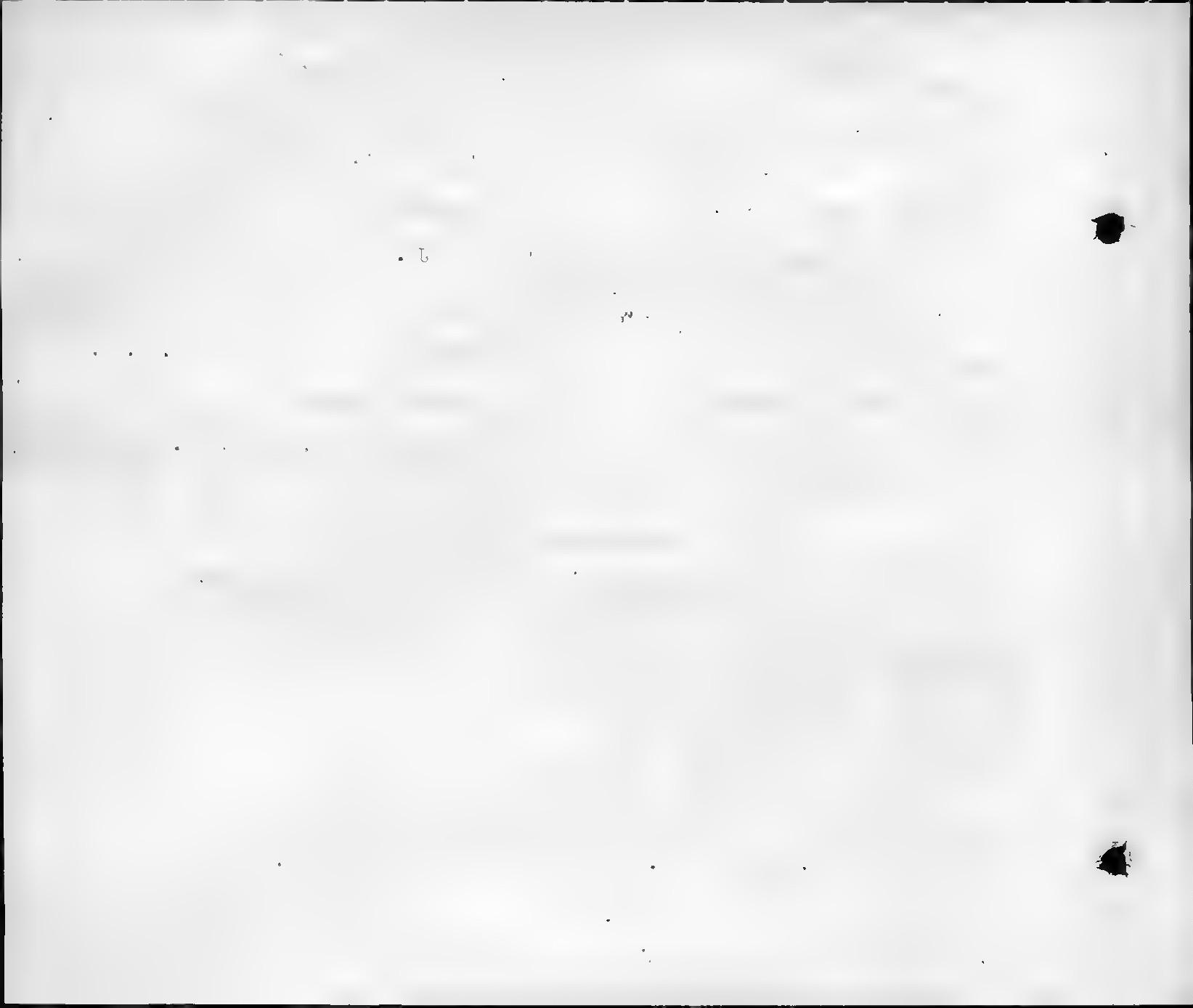
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 and be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

(03230)

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY HOWARD		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 2 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLIOTT CITY		d. STREET ADDRESS WOODLAWN FARM		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) CHARLES EARL COLEBRT JR.		First	Middle	Last	4. DATE OF DEATH MARCH 12 1961	Month	Day	Year
S. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/2/12	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME CHARLES COLEBRT				14. MOTHER'S MAIDEN NAME MATTIE WILLIAMS		Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		HOSPITAL RECORDS, OLNEY, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute cardiac failure DUE TO (c) Extensive bilateral bronchial pneumonia DUE TO INTERVAL BETWEEN ONSET AND DEATH 2 hours								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (his hospital) attended the deceased from 3/3/1961 to 3/12/1961, and that death occurred at 9:50 p.m. M, from the causes and on the date stated above.		22b. DATE SIGNED 3/13/61						
22c. SIGNATURE Charles S. Whitaker		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						
22c. PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M. D.		22d. ADDRESS CLARKSVILLE, MD.						
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-16-61		23c. NAME OF CEMETERY OR CREMATORIUM St. Louis		23d. LOCATION (City, town, or county) (State) Clarksville, Md		
24. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE Clifford L. Keene		
				MAR 15 '61				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3243

CERTIFICATE OF DEATH

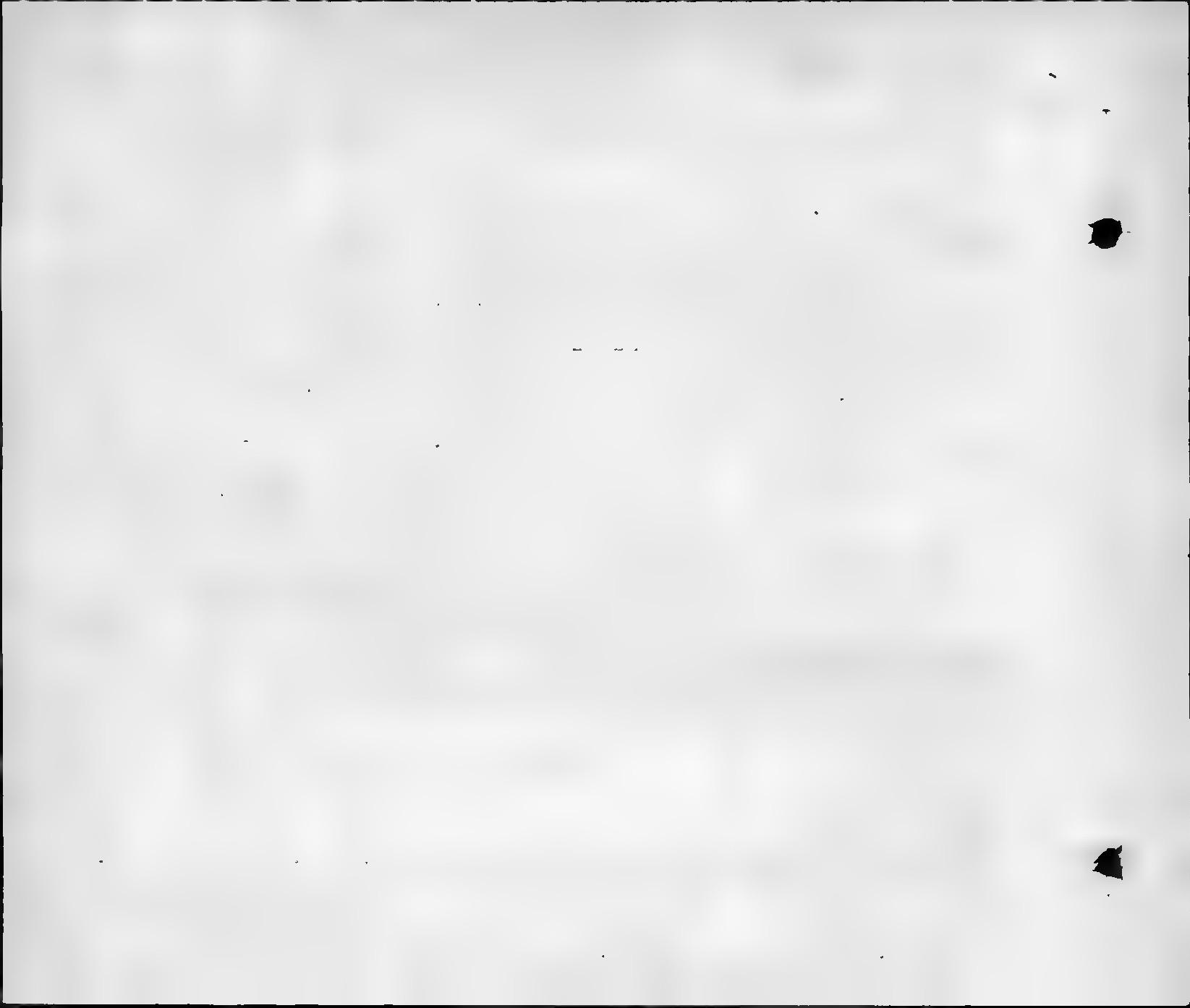
Reg. Dist. No.

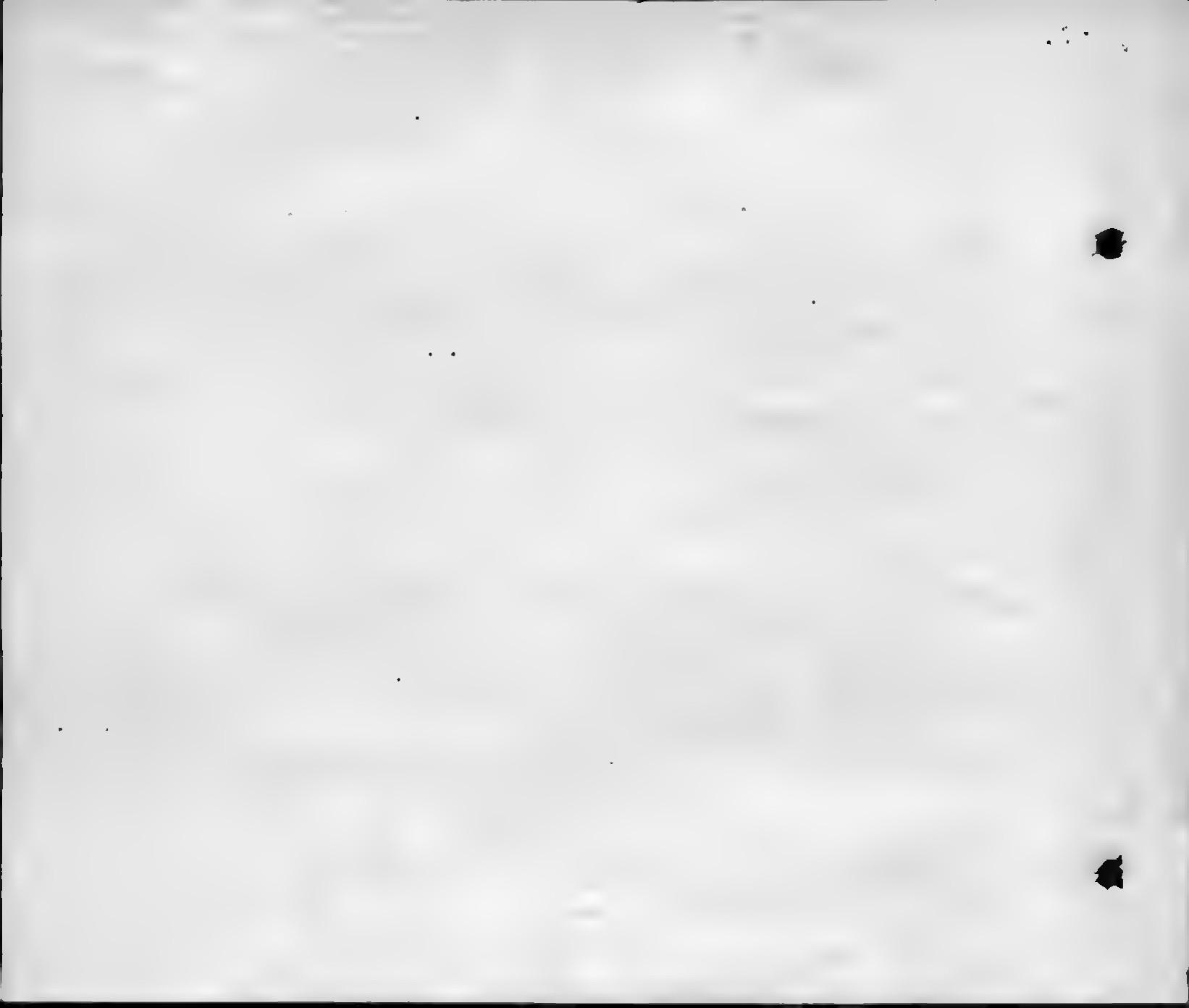
03231

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 4858 Battery Lane		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4858 Battery Lane				d. STREET ADDRESS 4858 Battery Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Alice		First	Middle	Last	4. DATE OF DEATH Cramer	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1881	9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0	12. IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Winfield S. Epler				14. MOTHER'S MAIDEN NAME Mary Cunningham				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO None		17. INFORMANT William E. Cramer, Jr.—Son-Bethesda, Md		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Causes of death: Conway heart disease, congestive heart failure				INTERVAL BETWEEN ONSET AND DEATH 3 days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6450 Wisc. Ave., Bethesda, Md.		20f. (City or town) (County) Rockville (State) Maryland		
21. I certify that I attended the deceased from Feb. 5, 1961 to March 4, 1961 , that I last saw the deceased alive on March 3, 1961 , and that death occurred at 10:45 AM , from the causes and on the date stated above.								
ACTUAL SIGNATURE Dr. Joseph Kendrick				ADDRESS (Street, city or town, state) 6450 Wisc. Ave., Bethesda, Md.		DATE SIGNED 3/14/61		
PHYSICIAN'S NAME (Type) Dr. JOSEPH KENDRICK		6450 Wisc. Ave. Bethesda, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/7/61		22c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery		22d. LOCATION (City, town, or county) Rockville, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR MAR 8 '61		24b. REGISTRAR'S SIGNATURE Robert A. Pumphrey		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1-2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please initial the certificate, writing the word "pending" in pencil in item 2. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

32 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03203

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN 16

MARYLAND

D.O.A.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Wash San + Hosp

3. NAME OF
DECEASED
(Type or print)

First Middle Lawrence Waller

4. SEX

m w

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Salesman

13. FATHER'S NAME

10b. KIND OF BUSINESS OR INDUSTRY

BUSINESS MACH

Bell & Howell Co.

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)

a. STATE

Maryland

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Chillum

d. STREET ADDRESS

1420 EAST WEST Hwy

e. IS RESIDENCE
ON A FARM?

YES NO

5. DATE
OF
DEATH

Dalton 3 15 1961

6. AGE (In years)
Last birthday 55
Months 05
Days 00
Hours 00
Min. 00

7. BIRTHPLACE (State or foreign country)
VIRGINIA

12. CITIZEN OF WHAT COUNTRY
U.S.A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and date of service)

No

16. SOCIAL SECURITY NO.

265-01-9543

17. INFORMANT

Mrs Rae Dalton

Address

Same as deceased

18. CAUSE OF DEATH (Enter only one cause per line for [a], [b], and [c].)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE [b]

DUE TO

Conditions, if any, which
gave rise to immediate cause
(e), stating the underlying
cause last.

[b] DUE TO

[c] DUE TO

ACUTE CONGESTIVE HEART FAILURE

LEFT CORONARY SCLEROSIS, SEVERE

RIGHT CORONARY Occlusion, OLD.

INTERVAL BETWEEN
ONSET AND DEATH

1 HOUR

YEARS

ASPIRATION OF STOMACH CONTENT

1 Hour

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITIONED IN PART I(e)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour a.m. 19
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from Natural causes Accident , Suicide , Homicide , Undetermined manner

CHIEF MEDICAL EXAMINER

ACTUAL SIGNATURE *Frank J. Borschert* DATE SIGNED *8-16-61*

EXAMINER'S NAME (Type) *FRANK J. Borschert* M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

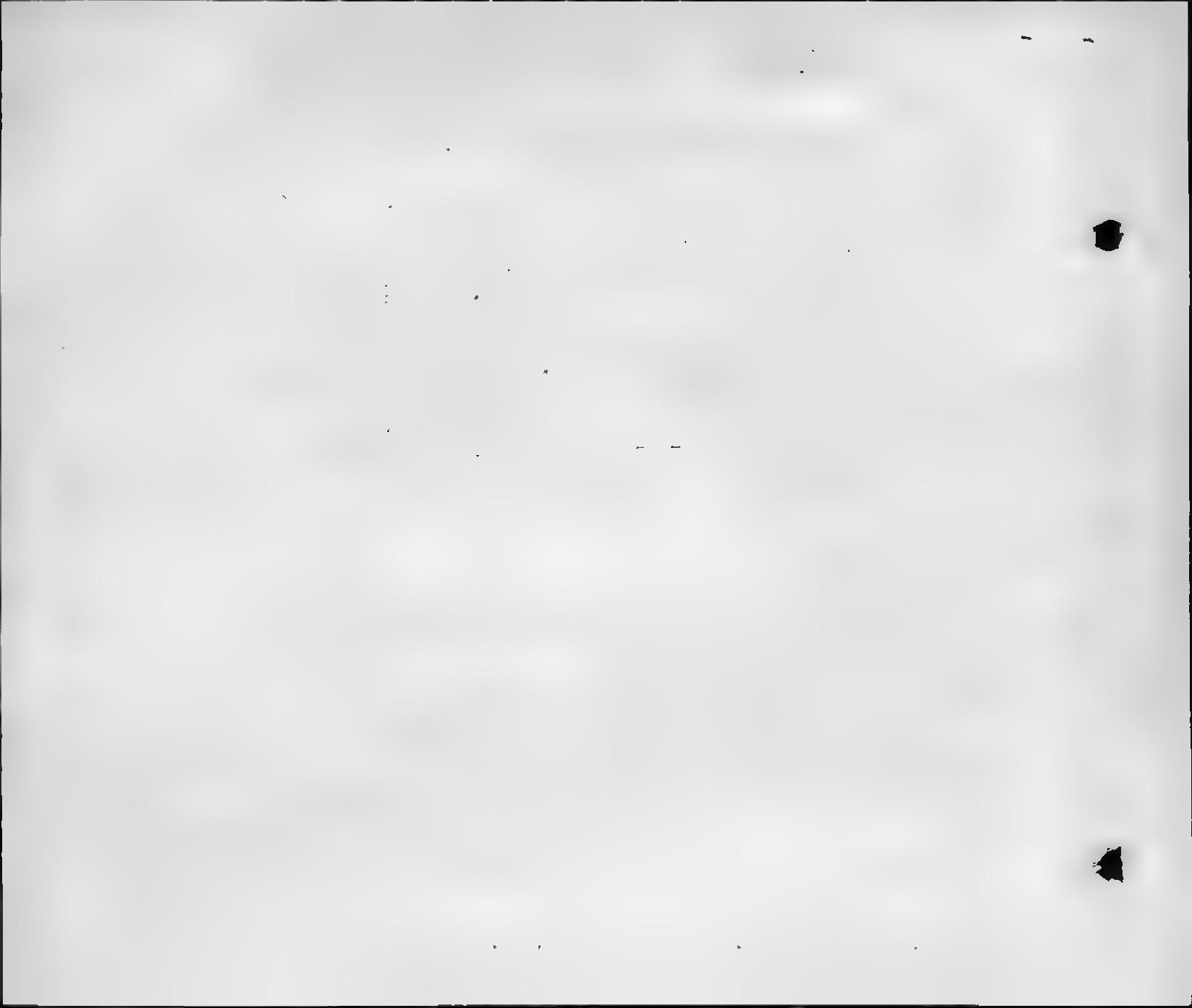
22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIAL 22d. LOCATION (City, town, or county) (State)

BURIAL 3/18/61 Oak Hill Cemetery Fredericksburg, Virginia

23. FUNERAL DIRECTOR *Raymond A. Ziska* ADDRESS *SILVER SPRING, MD.* 24a. REC'D BY REGISTRAR *Cathleen S. Kraus* 24b. REGISTRAR'S SIGNATURE

VS. AT 15ME
5M 7/59

DATE MAR 20 '61



HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3246

03234

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN IB

22 hrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Suburban Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Roy

L.

4. SEX

6. COLOR OR RACE

Male

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

13. FATHER'S NAME

Thomas G. Davies

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war record dates of service)

No

16. SOCIAL SECURITY NO. I 17

Yes

Unknown

7. MARRIED

NEVER MARRIED

MARRIED

DIVORCED

WIDOWED

SEPARATED

UNKNOWN

b o s

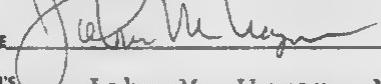
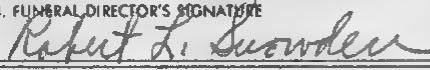
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3247

CERTIFICATE OF DEATH

Reg. Dist. No.

03255

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE [Where deceased lived, if institution, Residence before admission] b. STATE	
Montgomery MARYLAND		Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 6221 Tilden Lane	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Claude L	Middle Davis
S SEX	6 COLOR OR RACE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 17, 1891
Male			9. AGE (in years last birthday) 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Interior Decorator		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Michigan	
		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
		17. INFORMANT Mrs. Myrtle V. Davis 3221 Tilden Lane., Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		myocardial infarction	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (b)		coronary heart disease c hypertension	
DUE TO (c)		arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Feb. 28, 1955, to 10 Mar. 1961, that I last saw the deceased alive on 7 Mar., 1961, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state)		DATE SIGNED 3/15/61	
ACTUAL SIGNATURE 		M.D. 7801 Norfolk Avenue	
PHYSICIAN'S NAME (Type)		John M. Wyman, M. D. Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/15/61	22c. NAME OF CEMETERY OR CREMATORIAL Oak Grove,
		22d. LOCATION (City, town, or county) Mt. Zion, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS Rockville, Md.	24a. REC'D BY REGISTRAR DATE MAR 20 '61
		24b. REGISTRAR'S SIGNATURE Catherine S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3248

CERTIFICATE OF DEATH

03256

1. PLACE OF DEATH

a. COUNTY

MONTGOMERY

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

SILVER SPRING

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

721 DALE DRIVE

**3. NAME OF
DECEASED
(Type or print)**

First

Middle

ELSIE

C.

DAVIS

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. MARRIED

WIDOWED

NEVER MARRIED

DIVORCED

B. DATE OF BIRTH

7/27/73

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOMEMAKER

10b. KIND OF BUSINESS OR INDUSTRY

OWN HOME

11. BIRTHPLACE (County & State, or foreign country)

BURLINGTON, IOWA

13. FATHER'S NAME

GEORGE P. CARPENTER

14. MOTHER'S MAIDEN NAME

ELLA HARMON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war record dates of service)

NO

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

Mr. Edwin C. Davis, 721 Dale Drive

Address

Silver Spring, Md.

INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a).

170X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Sclerosing Carcinoma, Right Breast

Metastasis to Dorsal Spine

2 yrs

MEDICAL CERTIFICATION

20e. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

Diabetes Mellitus

19. WAS AUTOPSY PERFORMED?

YES NO

20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m.

20d. INJURY OCCURRED
While at work Not White at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

19

21. I certify that (I) (this hospital) attended the deceased from April 25, 1966, to March 27, 1961, that (I) (we) last saw the deceased alive on March 25, 1961, and that death occurred at 11:30 PM, from the causes and on the date stated above.

22e. SIGNATURE

Merrill M. Cross, M.D.
MERRILL M. CROSS M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22d. ADDRESS

8248 BEAVERS AVE
SILVER SPRING, MD. MARYLAND

22b. DATE
SIGNED
3/27/61

23a. BURIAL, CREMATION REMOVAL (Specify)

CREMATION

3/27/61

23c. NAME OF CEMETERY OR CREMATORIAL

FT. LINCOLN CREMATORIAL

23d. LOCATION (City, town or county)

PRINCE GEO. COUNTY, MARYLAND

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

Raymond L. Ziska
INC.

ADDRESS

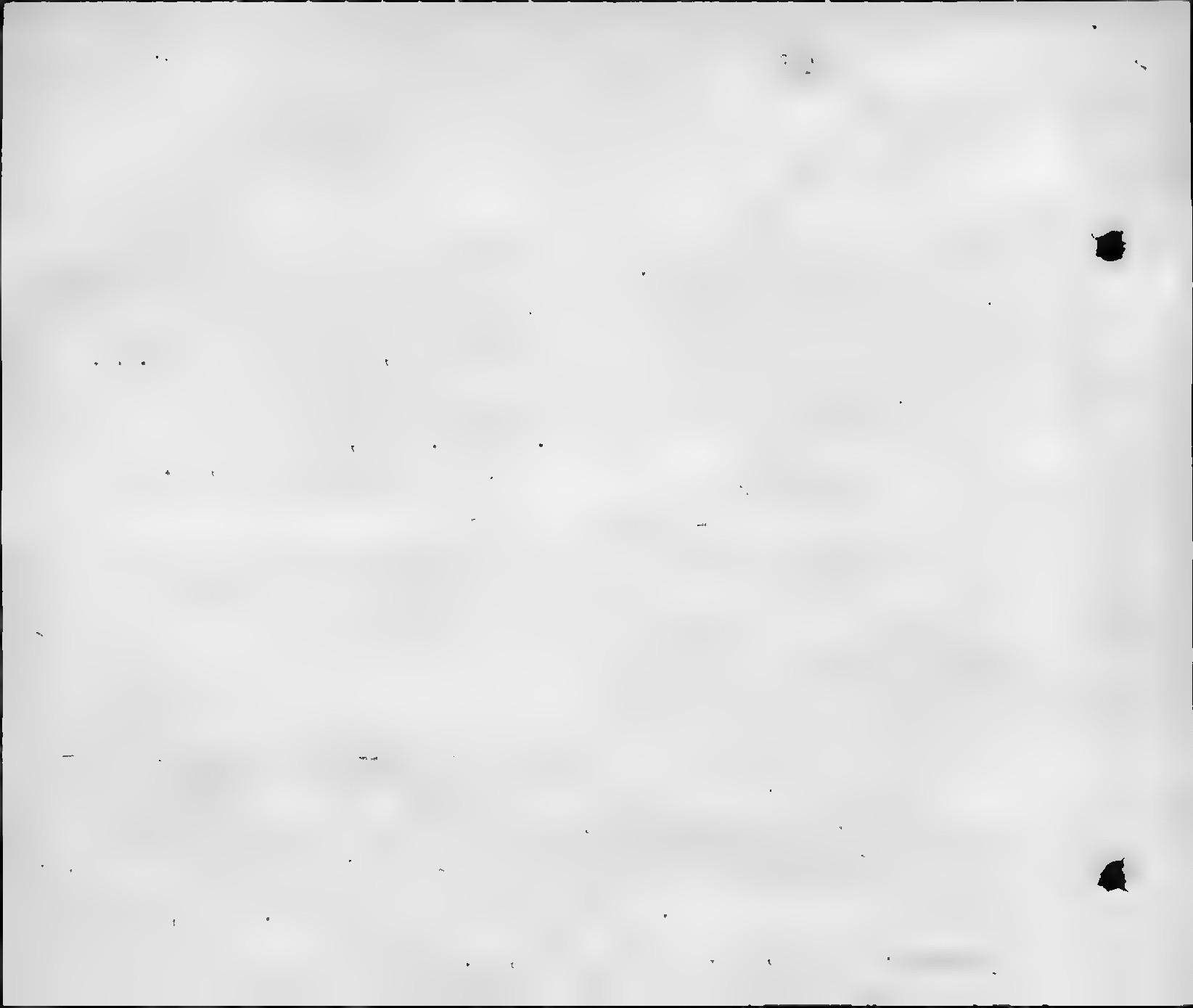
SILVER SPRING, MD.

25e. REC'D BY REGISTRAR

DATE 3 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please initial the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3249 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13287

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

c. LENGTH OF STAY IN lb

3 mo

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

10705 Huntley Place

First

Middle

Last

3. NAME OF
DECEASED
(Type or print)

REGINA

Davis

4. DATE
OF
DEATH

Mar 28 1961

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

2-9-1895

9. AGE (In years
last birthday)

66 yrs.

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min.

10b. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

housewife

11. KIND OF BUSINESS OR INDUSTRY

OWN HOME

11. BIRTHPLACE (State or foreign country)

N.Y.

12. CITIZEN OF WHAT COUNTRY?

n.s.a.

13. FATHER'S NAME

Edward Humphrey

14. MOTHER'S MAIDEN NAME

Susan Wise

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.

(Yes, no, or unknown) (If yes, give rank and dates of service)

17. INFORMANT

Shirley Marion - Ida

NO

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause first.

(b)

DUE TO

(c)

NONE
Coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH
sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m. 19

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20d. INJURY OCCURRED While Not While
at work at work
20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)
20f. (City or town)
(County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry and in my opinion
death resulted from Natural causes Accident , Suicide , Homicide , Undetermined manner

CHIEF MEDICAL EXAMINER

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Frank J. Brochert

DATE SIGNED

22a. BURIAL, CREMATION,
REMOVAL (Specify)

TRANS. & BURIAL 4/3/61

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

GALVANY CEMETERY

ADDRESS

SILVER SPRING, MD.

22d. LOCATION (City, town, or country)

ERIE, PENNSYLVANIA

(State)

24e. REC'D BY REGISTRAR APR 3 '61

24b. REGISTRAR'S SIGNATURE

Arthur L. Thomas



1
FOR STATE
HEALTH DEPT.

M

Please initial the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3250 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03238

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN 1B

3 days

d. NAME OF HOSPITAL OR INSTITUTION (if not a hospital, give street address)

Wash. SAN + Hosp

3. NAME OF
DECEASED
(Type or print)

ROBERT Allan Davis

4. SEX

m

6. COLOR OR RACE

Cauc

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Last

Month

Year

d. STREET ADDRESS

1441 SPRING Rd, NW

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3251

CERTIFICATE OF DEATH

03251

1. PLACE OF DEATH

a. COUNTY
Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Takoma Park 12, Md 1 day

c. LENGTH OF STAY IN 16

MARYLAND

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington Sanitarium and Hospital

NAME OF
DECEASED
(Type or print)

First
Mrs. MAY

Middle
LOUISE

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Maryland

b. COUNTY Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

d. STREET ADDRESS

200 E. Franklin Ave.

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First
Mrs. MAY

Middle
LOUISE

Last
DAYTON

4. DATE
OF
DEATH

Month
March

Day
6, 1961

5. SEX

Female

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

6-29-02

9. AGE (in years
last birthday)

58 yrs.

IF UNDER 1 YEAR
Months Days

IF UNDER 24 HRS.
Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired.)

Housewife
Secretary

10b. KIND OF BUSINESS OR INDUSTRY

OWN HOME
Transfer & Storage Co.

11. BIRTHPLACE County & State or foreign country

District of Columbia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

Yulee Hodges

Edith Keniston

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

578-03-2196

17. INFORMANT

Patients Chart

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

170X

DEUE TO

Conditions, T any, which
gave rise to immediate cause
(a), stating the underlying
cause last

b)

DEUE TO

(c)

Congestive heart failure

Metastatic carcinoma to lungs

Adenocarcinoma of both breasts

INTERVAL BETWEEN
ONSET AND DEATH

2 days

about 2 months

about 5 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury Part II or Part III of form 1B)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

20d. INJURY OCCURRED

While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

p.m.

19

at work

21. I certify that (I) (this hospital) attended the deceased from 2-24, 1947 to 3-6, 1961, that (I) (we) last saw the deceased alive on March 6, 1961, and that death occurred at 4 P.M. from the causes and on the date stated above

22. SIGNATURE

Benjamin Isaacson, M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED

3/6/61

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

DATE THEREOF

3/9/61

23c. NAME OF CEMETERY OR CREMATORIAL

CEDAR HILL CEMETERY

ADDRESS

SILVER SPRING, MD.

23d. LOCATION (City, town or county)

PRINCE GEORGE COUNTY, MD.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

WARNER E. PUMPHREY INC.

Raymond E. Gasko

25a. REC'D BY REGISTRAR

MAR 10 1961

REGISTRAR'S SIGNATURE

Calvin S. Evans



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3252

CERTIFICATE OF DEATH

03240

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Silver Spring

c. LENGTH OF STAY IN lb

MARYLAND

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

910 Newhall Street

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

CHARLES

EDWARD

DELAMaison

4. DATE
OF
DEATH

Month

Day

Year

March

26

1961

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

Oct. 11. 1888

9. AGE in years
last b'day

72 yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Painter

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Sam

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Edward M. Delamaison

14. MOTHER'S MARRIED NAME

Caroline Louise Ponai

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Mrs. Helen K. Delamaison (Same as #2)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

416X

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Congestive Cardiac Failure

Rheumatic Heart Disease

INTERVAL BETWEEN
ONSET AND DEATH
Six Mos.

2 years

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY
Hour o.m.
p.m.

Month, Day, Year
19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. CITY OR TOWN
(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 1957 to March 26, 1961, that (I) (we) last saw the deceased alive on March 26, 1961, and that death occurred at 11:20 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Robert A. Hare

M.D.

ATTENDING
PHYS

MED
DIRECTOR

STAFF
PHYS

22b. DATE
SIGNED
March 27, 1961

22c. PHYSICIAN'S
NAME (Type)

Robert A. Hare M.D.

22d. ADDRESS

9600 Carroll Ave, T. Park Md.

(State)

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

March 29, 1961

23c. NAME OF CEMETERY OR CREMATORIUM

Kirk Creek Cemetery

23d. LOCATION (City, town or county)

Washington

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

J. Luther Gentry, 254 Carroll St. N.W. 10

ADDRESS

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE MAR 28 '61

Arthur S. Thomas



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M
I

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3253

CERTIFICATE OF DEATH

03241

1. PLACE OF DEATH.
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Germantown

c. LENGTH OF STAY IN lb

1 yr

d. NAME OF HOSPITAL OR INSTITUTION (if not a hospital, give street address)

The Karylander Home of Rest

3. NAME OF
DECEASED
(Type or print)

Catherine

First Middle

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

5. SEX

6. COLOR OR RACE

Female

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House Wife

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Derosia

Dec 18-1881

4. DATE
OF
DEATH

Jan 25th

Month Day Year

19 61

19. AGE (in years last birthday) IF UNDER 1 YEAR Months Days Hours Min.

79 yrs.

3 17

U.S.A.

12. CITIZEN OF WHAT COUNTRY?

Ireland

14. MOTHER'S MAIDEN NAME

Bridget McCormack

2701 S. Uhle St

Arlington, Va.

INTERVAL BETWEEN
ONSET AND DEATH
10 years

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

4221

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause first.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 10, 1954 to March 25, 1961, that (I) (we) last saw the deceased alive on March 25, 1961, and that death occurred at 9 A.M. from the causes and on the date stated above.

22e. SIGNATURE

James P. Kerr

22e. PHYSICIAN'S
NAME (Type)

James P. Kerr

ATTENDING
PHYS. MED.
DIRECTOR STAFF
PHYS.

22d. ADDRESS

March 28, 1961
SIGNED
March 28, 1961

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial 3-29-61

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

Glenwood

ADDRESS

23d. LOCATION (City, town or county)

(State)

N.Y.

24. FUNERAL DIRECTOR'S SIGNATURE

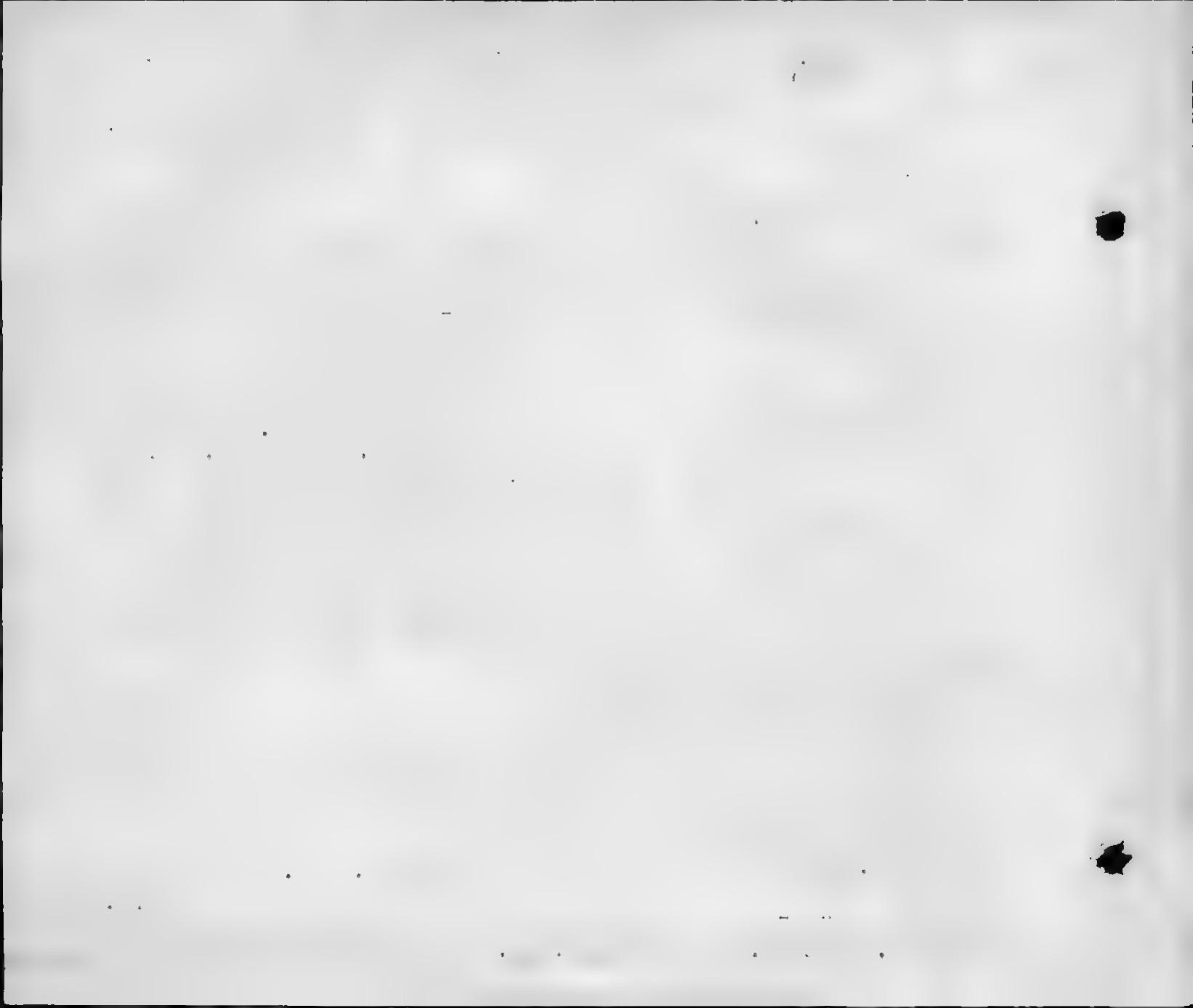
Ernest G. Gartner, Gaithersburg

25e. REC'D BY REGISTRAR DATE

MAR 28 '61

25f. REGISTRAR'S SIGNATURE

Arthur S. Times



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 To be used by the hospital or attending physician
BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Part 2 should be filed with the State Board of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

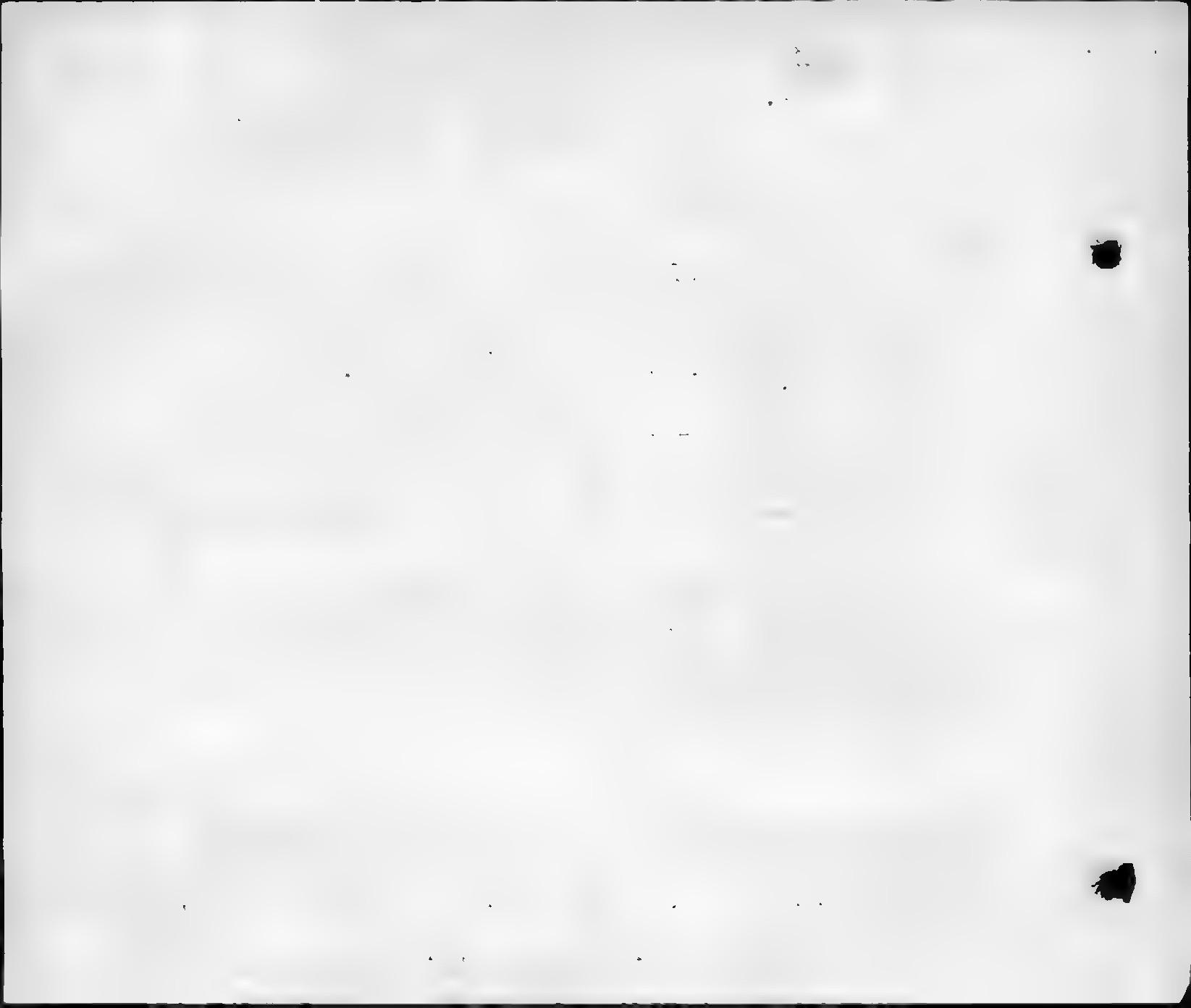
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3254

03242

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 30 days		c. CITY OF TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 405 Thayer Avenue									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Frederick		First	Middle	Lost	4. DATE OF DEATH March	Month	Day	Year							
S. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 2, 1904	9. AGE (In years last birthday) 56 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.						
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Repeco		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME WILLIAM F. DIESTE				14. MOTHER'S MAIDEN NAME K. Elizabeth Spengler		Address									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 577-09-3928		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Atrial fibrillation & Cardiac Failure		INTERVAL BETWEEN ONSET AND DEATH 4 m o							
18b. CONDITONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE (b) Chronic Cirrhosis of Liver		b. (b) Diabetes Mellitus		b. (c) Chronic Nephritis & Uremia				INTERVAL BETWEEN ONSET AND DEATH Undetermined							
								PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Giant Arthritis Bilateral hip joints		b. (b) Undetermined		b. (c) Undetermined		b. (d) Undetermined	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) Silver Spring, Maryland							
21. I certify that (I) (this hospital) attended the deceased from Nov 1, 1960 to Mar 6, 1961 , that (I) (we) last saw the deceased alive on Mar 5, 1961 , and that death occurred at 6:00 AM , from the causes and on the date stated above		22a. SIGNATURE George L. Ball		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Mar 6, 1961									
22c. PHYSICIAN'S NAME (Type) George L. Ball		22d. ADDRESS 15629 Georgia Ave Silver Spring, Md		23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 3/8/61		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORIUM							
24. FUNERAL DIRECTOR'S SIGNATURE Ronald J. Spafford		ADDRESS Spafford & Humphrey, Inc. Silver Spring, Maryland		25a. REC'D BY REGISTRAR MAR 10 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3255

CERTIFICATE OF DEATH

03243

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 7 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA	
3. NAME OF DECEASED (Type or print) First MACK Middle MCCLINTON Lost ECKENRODE		d. STREET ADDRESS 4818 DELRAY AVENUE	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 5-4-1880	
9. AGE (In years last birthday) 80 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator Operator		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
10c. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME JOSEPH ECKENRODE		14. MOTHER'S MAIDEN NAME ADA HONOR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Vaccinia</i>		INTERVAL BETWEEN ONSET AND DEATH 5 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized ortho solvus</i>		DUE TO 10 JUN	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 1955 to March 31, 1961 , that (I) (we) last saw the deceased alive on March 31, 1961 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.		22b. DATE SIGNED 3-31-61	
22c. PHYSICIAN'S NAME (Type) A. D. BONIFANT, M. D.		22d. ADDRESS SANDY SPRING, MARYLAND	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 4-3-61	
23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		23d. LOCATION (City, town or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY,		ADDRESS Bethesda, Md.	
25a. REC'D BY REGISTRAR DATE APR 5 '61		25b. REGISTRAR'S SIGNATURE S. Krum	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3256

CERTIFICATE OF DEATH

Reg. Dist. No. 03244

1. PLACE OF DEATH o. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7504 Piney Branch Rd.		d. STREET ADDRESS 7504 Piney Branch Rd.	
3. NAME OF DECEASED (Type or print) GEORGE		First	Middle
4. SEX Male	5. COLOR OR RACE White	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH April 8, 1895		9. AGE (In years last birthday) 65 yrs	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Germany	
13. FATHER'S NAME ABRAHAM ELKAN		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO INFORMANT Gerald Elkan - 7504 Piney Branch Rd., Ss., Md.	
17. Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Leukemia, chronic (lymphatic & myeloid) 4.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I(o) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 61 , to March 15 , 19 61 , that I last saw the deceased alive on March 13 , 19 61 , and that death occurred at 5:30 A.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Alvin W. Eger, M.D. 1801 Eye Street, N.W. Washington, DC		21. ACTUAL SIGNATURE Alvin W. Eger	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-16-61	
22c. NAME OF CEMETERY OR CREMATORIUM National Capital Hebrew Cemetery		22d. LOCATION (City, town, or county) Washington, DC	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons-3501 14th St., NW		24a. REC'D BY REGISTRAR DATE MAR 17 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3257

CERTIFICATE OF DEATH

Item 9 Film 8252

3/9/61 mbr

03245

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outsd.corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Suburban Hospital

3. NAME OF
DECEASED
(Type or print)

First

M dd a

Dorothy

Ellis

4. SEX

6. COLOR OR RACE

Female

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Secretary

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

3/3/05

4. DATE
OF
DEATH

March

4

19

61

9. AGE (In years last birthday) IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

56 57 yrs.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harry St. George

14. MOTHER'S MAIDEN NAME

Ora Hood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If yes, give award date of service)

No

556-040343

Address

Mrs. Elizabeth Tallon Rockville, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)DUE TO
(b)Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.DUE TO
(c)INTERVAL BETWEEN
ONSET AND DEATH

37 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED

While
at work Not While
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

saw the deceased alive on 3/14/1961, and that death occurred at 2:47 P.M. from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)
Stephen N. JonesATTENDING
PHYS. MED.
DIRECTOR STAFF
PHYS.

22d. ADDRESS

22b. DATE
SIGNED
3/17/61

Rockville, Md.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

CREMATION

3-6-61

24. FUNERAL DIRECTOR'S SIGNATURE

B. Langansky & Sons

3501 14th, N.W.

D.C.

23b. DATE THEREOF

CEDAR HILL CREMATORIUM

ADDRESS

3501 14th, N.W.

D.C.

3/17/61

D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3258

CERTIFICATE OF DEATH

Reg. Dist. No. 03246

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) b. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL (If not in hospital, give street address) e. OR INSTITUTION Resmor Sanitarium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ANNIE	Middle LAURIE	Last EVANS
4. DATE OF DEATH	Month March	Day 5,	Year 19
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17, 1884
9. AGE (In years lost birthday) 76	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Louisiana	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JAMES L. TAYLOR	14. MOTHER'S MAIDEN NAME ANNIE LOUISE?	INFORMANT Sanitarium Records...	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) No	16. SOCIAL SECURITY NO NO	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) DUE TO (d) DUE TO			
<i>Arterio sclerotic Heart disease</i> <i>Stroke due to Arterio sclerosis</i>			
INTERVAL BETWEEN ONSET AND DEATH 3 yrs.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture R. hip - Fall Jan 1961			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) Fall		
20c. TIME OF INJURY Month, Day, Year Hour a. m. Jan 1961 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) At Resmor San.	20f. (City or town) (County) (State) Montgomery Co. Md.
21. I certify that I attended the deceased from 1958 , 19, to 3-5 , 1961, that I last saw the deceased alive on 3-5 , 1961, and that death occurred at 3:20 P.M. from the causes and on the date stated above.	ADDRESS (Street, city or town, state) George R. Huffman, 1912 R. Street, NW., Washington, D. C.		
ACTUAL SIGNATURE <i>Geo. R. Huffman</i>	DATE SIGNED 3/5/61		
PHYSICIAN'S NAME (Type) George R. Huffman, 1912 R. Street, NW., Washington, D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-8-1961	22c. NAME OF CEMETERY OR CREMATORIUM Oak Hill Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Hawley & Sons</i>	ADDRESS Washington, D. C.	24a. REC'D BY REGISTRAR MAR 8 '61	24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3259

CERTIFICATE OF DEATH

03247



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery County</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) b. COUNTY <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>4 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanatorium and Hospital</i>		d. STREET ADDRESS <i>8515 Flora Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Bassie</i>		First <i>Bassie</i>	Middle <i>IDA</i>
4. DATE OF DEATH <i>MARCH 5, 1961</i>		Last <i>Everdale</i>	Month <i>MARCH</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>4-23-80</i>		9. AGE (In years last birthday) <i>80 yrs</i>	
10a. JSJAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>11. BIRTHPLACE (County & State, or foreign country) <i>Germany</i></i>	
13. FATHER'S NAME <i>Theodore Schrumm</i>		14. MOTHER'S MAIDEN NAME <i>Primer</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank or date of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>17. INFORMANT Address Shoe Washington Sanatorium & Hospital</i>	
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO Condition which gave rise to immediate cause (a), stating the underlying cause last. <i>b</i>) DUE TO (b) DUE TO (c)		20. INTERVAL BETWEEN ONSET AND DEATH <i>24 hr</i> <i>4 days</i>	
21. PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes mellitus E</i>		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
22a. ACCIDENT WAS UNDERLYING () OR CONTRIBUTING () CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 1b) <i>3/4/61 to 3/5/61</i>	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>20f. (City or town) (County) (State)</i>
21. I certify that (I) (this hospital) attended the deceased from <i>3/1/61</i> to <i>3/5/61</i> , that (I) (we) last saw the deceased alive on <i>3/4/61</i> , and that death occurred at <i>4:40 AM</i> , from the causes and on the date stated above.		22b. DATE SIGNED <i>7105 Riess Rd. Lauderdales Md.</i>	
22c. PHYSICIAN'S NAME (Type) <i>Hugh T. Grey</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. 22d. ADDRESS <i>7105 Riess Rd. Lauderdales Md.</i>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (specify) <i>Burial</i>		23b. DATE THEREOF <i>Mar 8 1961</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>St. Lincoln Cemetery</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>John O'Farrell</i>		ADDRESS <i>254 Carroll St NW</i>	D.C. 25a. REC'D BY REGISTRAR DATE <i>MAR 7 '61</i>
			25b. REGISTRAR'S SIGNATURE <i>Christine S. Kline</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician. Then please move carbon paper page 3 should be detached for use as the burial-transit Permit. Then file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

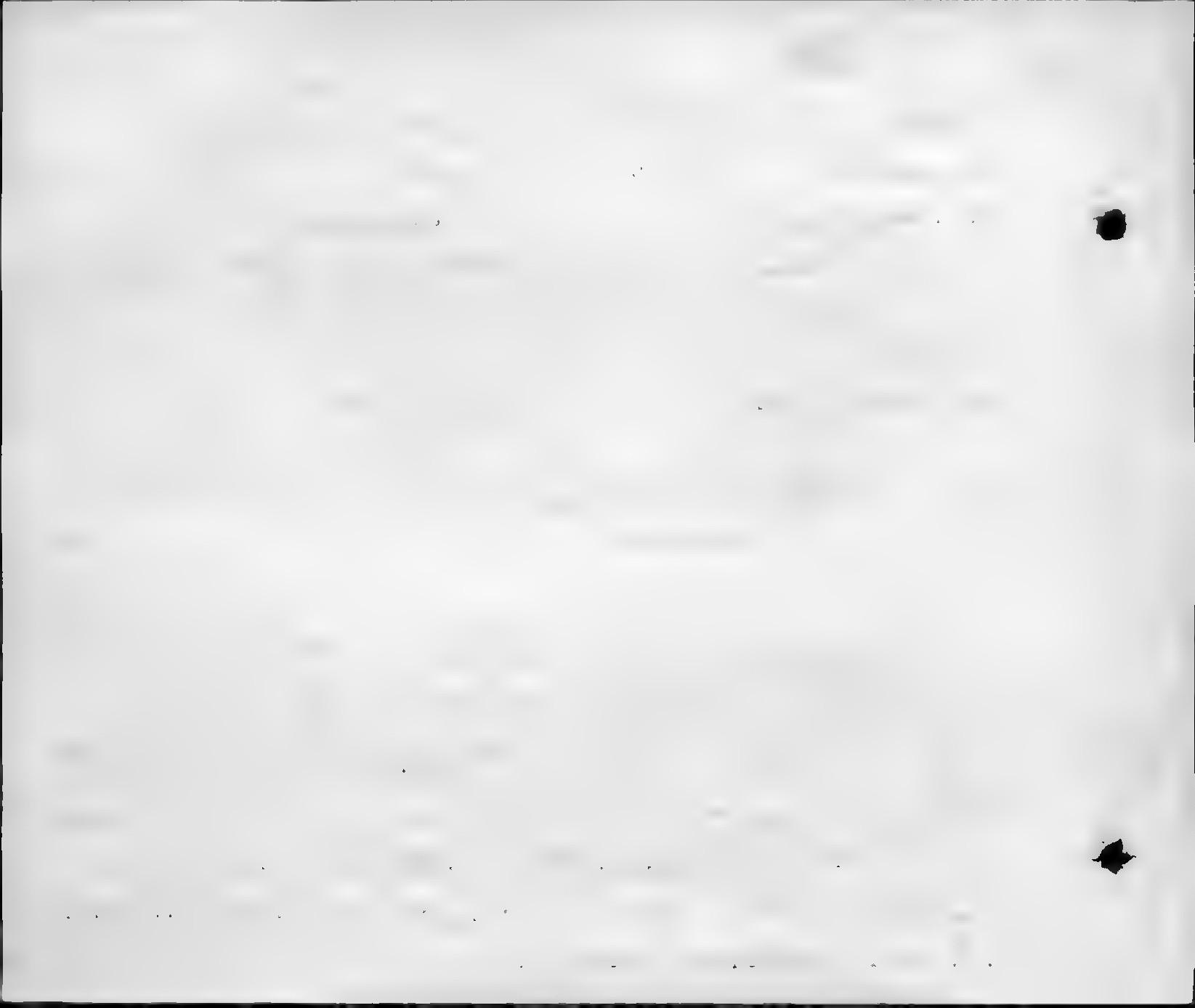
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3260

03248

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b 1 hr. 20 min.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 4927 Jamestown Road	
e. FIRST MIDDLE Victor Oris		f. LAST MONTH DAY FEIK March 18 1961	
3. NAME OF DECEASED (Type or print) Male Caucasian		g. DATE OF BIRTH 3-14-98	
4. SEX b. COLOR OR RACE Male Caucasian		h. IF UNDER 1 YEAR IF UNDER 24 HRS. 63 yrs. Months Days Hours Min	
i. MARRIED WIDOWED		j. BIRTHPLACE (County & State, or foreign country) Ohio	
k. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restauranteur		l. CITIZEN OF WHAT COUNTRY? USA	
m. KIND OF BUSINESS OR INDUSTRY Retired		n. MOTHER'S MAIDEN NAME Elizabeth LAUER	
o. FATHER'S NAME George Christian FEIK		p. ADDRESS	
q. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		r. SOCIAL SECURITY NO. s. INFORMANT	
t. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		u. INTERVAL BETWEEN ONSET AND DEATH 3 hours	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b) arterio sclerotic heart disease DUE TO (c)		v. 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		w. WAS AUTOPSY PERFORMED? Yes	
x. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		y. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
z. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		aa. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) bb. (City or town) (County) (State)	
cc. I certify that (I) attended the deceased from March 17 1961 to March 18 1961 , that (I) last saw the deceased alive on March 18 1961 , and that death occurred at M , from the causes and on the date stated above.		dd. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> ee. 22b. DATE SIGNED 3-18-61	
ff. SIGNATURE Vernon N. Houk		gg. 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
hh. PHYSICIAN'S NAME (Type) Vernon N. HOUK, LT, MC, USN		ii. NAME OF CEMETERY OR CREMATORIAL Hillcrest Memorial Park	
jj. BURIAL, CREMATION OR REMOVAL (Specify) Burial-Shipment		kk. DATE THEREOF 3-19-61	
ll. FUNERAL DIRECTOR'S SIGNATURE R. A. Pamphrey Funeral Home, Bethesda, Md.		mm. ADDRESS Sharon, Mercer Co., Pennsylvania	
nn. REC'D. BY REGISTRAR MAR 21 '61		oo. REGISTRAR'S SIGNATURE Arthur S. Kraus	



in by the funeral director,
may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely
filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Part 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

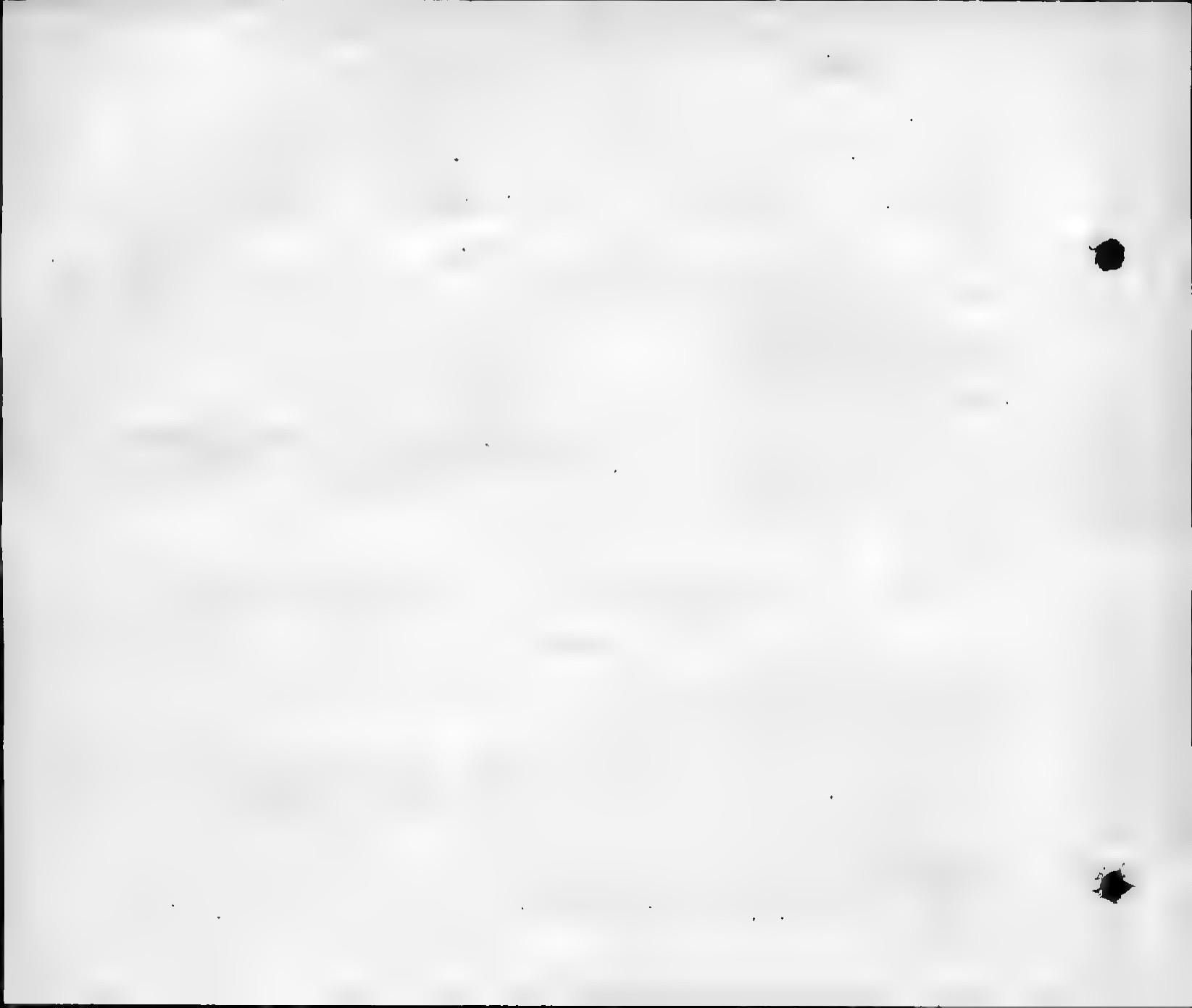
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3261

113243

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
<i>Montgomery</i>		MARYLAND <i>Va.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OR INSTITUTION		c. LENGTH OF STAY IN 1b <i>Takoma Park</i> 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Vienna</i>	
<i>Washington Sanitarium & Hospital</i>		d. STREET ADDRESS <i>845 Maple St.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>Lewis</i> Middle <i>Benton</i> Last <i>Flohr</i>	
4. DATE OF DEATH		Month <i>3</i>	Day <i>19</i> Year <i>1961</i>
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-20-73</i>
9. AGE (In years last birthday) yrs. <i>87</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <i>Retired Govt. employee</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Pa.</i>	
11. BIRTHPLACE (State or foreign country) <i>Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>A.S.Q.</i>	
13. FATHER'S NAME <i>John R. Flohr</i>		14. MOTHER'S MAIDEN NAME <i>Mary A. Green</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Address</i> <i>Washington San & Hospital Records</i>	
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</i>		(b) <i>Arteriosclerotic Heart Disease & Arthritis</i> DUE TO <i>Up known</i>	
(c)		<i>Fibr. Tissue</i>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Bilateral Bronchopneumonia</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>(County)</i> <i>(State)</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>3-15</i> 19 <i>61</i> , to <i>3-19</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>3-19</i> 19 <i>61</i> , and that death occurred at <i>8:30 PM</i> , from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE <i>Shane Nelson</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYS. C.I.A.N.'S NAME (Type) <i>None</i>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>March 23, 1961</i>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>National Memorial Park</i>		23d. LOCATION (City, town, or county) (State) <i>Falls Church, Virginia</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Money & King</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 21 '61</i>	
ADDRESS <i>Chew Davis</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3262

CERTIFICATE OF DEATH

113250

**1. PLACE OF DEATH
e. COUNTY**

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

U. S. Naval Hospital

**3. NAME OF
DECEASED
(Type or print)**

Steve

Nick

5. SEX

6. COLOR OR RACE

Male

Caucasian

10a. **USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired)

Tavern Owner

13. **FATHER'S NAME**

Tavern

FLOOR

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)

e. **STATE**

UTAH

c. **CITY OR TOWN** (If outside corporate limits, write RURAL and give nearest town)

Salt Lake City

d. **STREET ADDRESS**

4581 Holly Lane

Left

4

**4. DATE
OF
DEATH**

Month

March

Day

11

Year

**5. IS RESIDENCE
ON A FARM?**
YES NO

8IX-3

**9. AGE (In years
last birthday)**

42

yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS

Hours

Min

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE

County & State, or foreign country

Salt Lake City, UTAH

Address

12. CITIZEN OF WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

Catherine GIANICOPOULOS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank date of service)

YES WW II

16. SOCIAL SECURITY NO.

17. INFORMANT

unknown Mary "Z" FLOOR 5705 Wrightson Dr. McLean, Va.

**INTERVAL BETWEEN
ONSET AND DEATH**

2 Hours

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4 CARDIAC ARREST

DUE TO

4 Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

4 RHEUMATIC VALVULITIS, INACTIVE

(b)

(c)

AORTIC

STENOSIS AND INSUFFICIENCY.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED?

YES X **NO**

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m.

20d. INJURY OCCURRED
White Not White
at work at work

20e. PLACE OF INJURY (Home, farm
factory, street, office bldg., etc.)

20f. (City or town
(County) (State)

21. I certify that X (this hospital) attended the deceased from Mar. 5 1961 to Mar. 11 1961, that X (we) last saw the deceased alive on Feb. 11 1961, and that death occurred at M. from the causes and on the date stated above.

22a. SIGNATURE

Joseph E. Stitcher

22b. DATE SIGNED

3-11-61

22c. PHYSICIAN'S
NAME (Type)

Joseph E. Stitcher LT, MC, USN

M.D. ATTENDING PHYS.
MED DIRECTOR STAFF PHYS.

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial-Shipment

3-11-61

Mt. Olivet

23c. NAME OF CEMETERY OR CREMATORIAL

23d. LOCATION (City, town or county)

(State)

Salt Lake City

Utah

ADDRESS

1001 14 th. St. WDC.

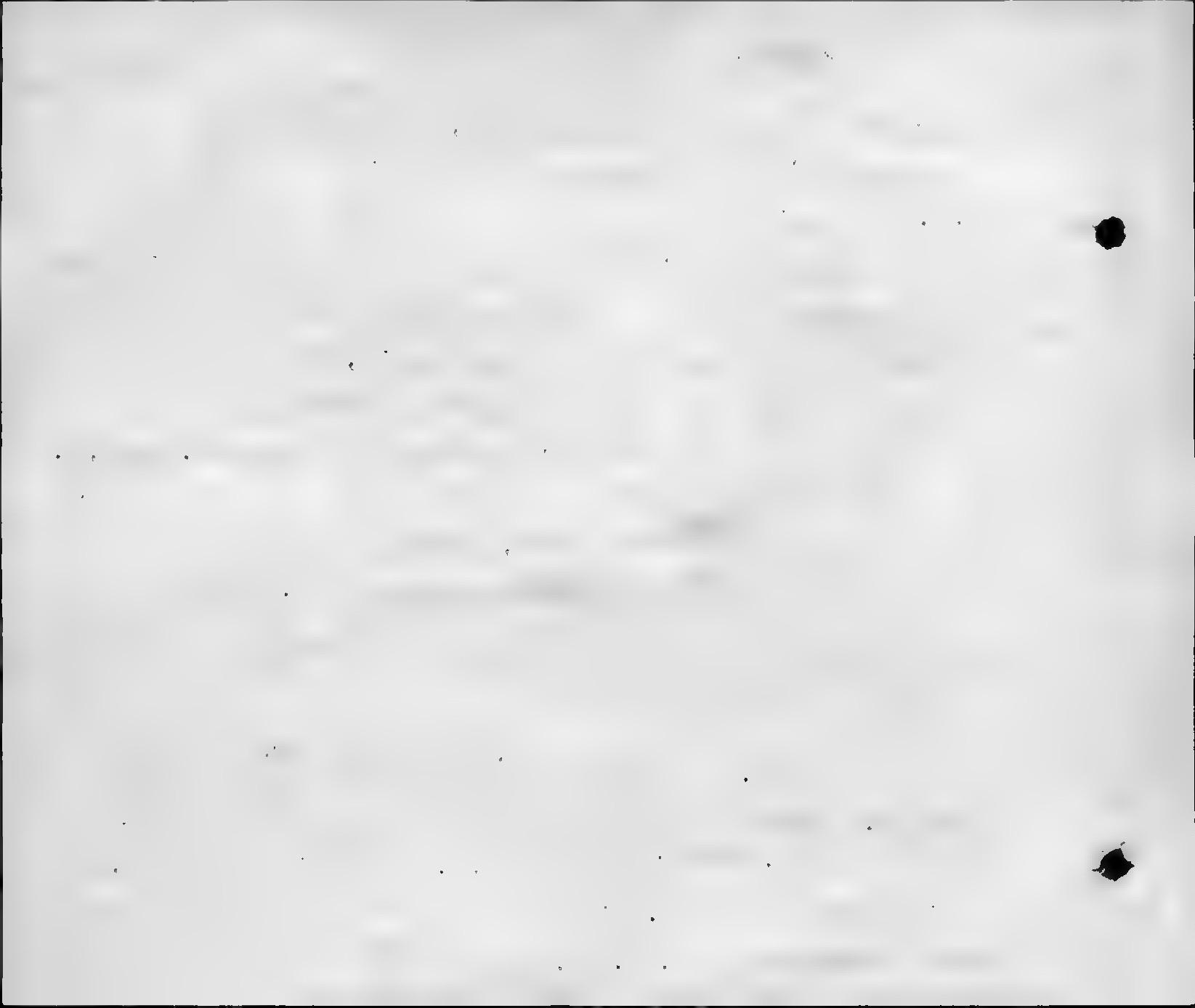
25a. REC'D BY REGISTRAR

Curtis S Krause

DATE MAR 14 '61

25b. REGISTRAR'S SIGNATURE

Curtis S Krause



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, Page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3263

103251

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 34 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		e. STREET ADDRESS R-1, Box 206	
3. NAME OF DECEASED (Type or print) WILLIAM THOMAS FLYNN		First WILLIAM	Middle THOMAS
Last FLYNN		4. DATE OF DEATH MARCH 23, 1961	Month Day Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH MAY 27, 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer	10b. KIND OF BUSINESS OR INDUSTRY Own farm	11. BIRTHPLACE (State or foreign country) MARYLAND	9. AGE (In years last birthday) 75 yrs
13. FATHER'S NAME THOMAS FLYNN		14. MOTHER'S MAIDEN NAME EMMA CRAWFORD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 10 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO (d) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) Long Corner, Md.
21. I certify that (I) (this hospital) attended the deceased from 10/11/60 to 3/23/61 , that (I) (we) last saw the deceased alive on 3/17/61 at 9:20 P.M. , and that death occurred at Long Corner, Md. from the causes and on the date stated above			
22a. SIGNATURE J. P. Kerr, M.D.	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 3/26/61	
22c. PHYSICIAN'S NAME (Type) J. P. KERR, M. D.	22d. ADDRESS DAMASCUS, MARYLAND		
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial	23b. DATE THEREOF 3/26/61	23c. NAME OF CEMETERY OR CREMATORIAL Howard Chapel	23d. LOCATION (City, town, or county) (State) Long Corner, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Olin L. Molesworth	ADDRESS Damascus, Md.	25a. REC'D BY REGISTRAR Arthur S. Kraus	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus
DATE MAR 28 '61		DATE MAR 28 '61	



1
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reported by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it may be detached from use as the burial transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

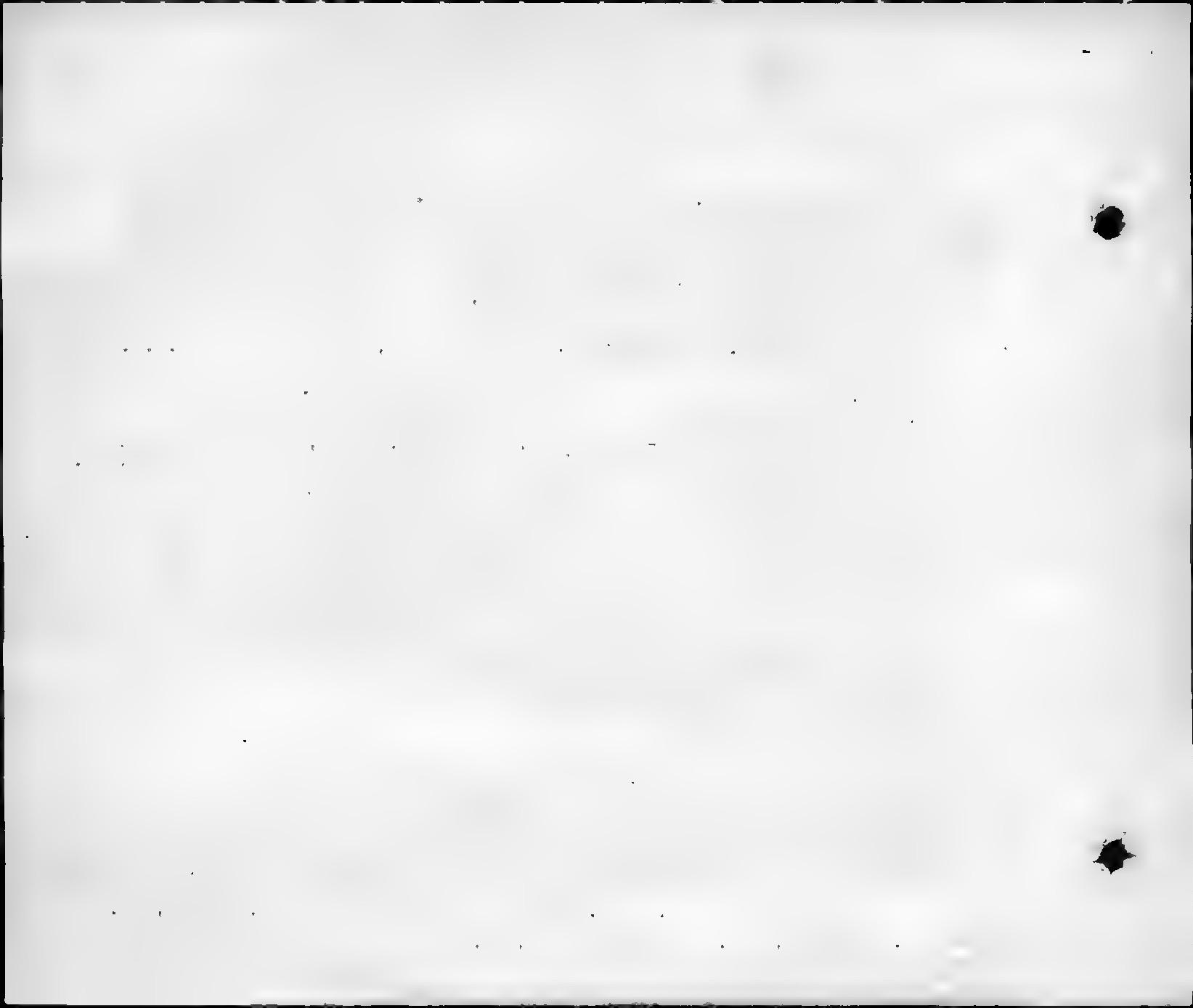
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3264

CERTIFICATE OF DEATH

03252

1. PLACE OF DEATH a. COUNTY MONTGOMERY			2. USUAL RESIDENCE (Where deceased lived if institution, Residence before adm is on) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK			c. LENGTH OF STAY IN 1b 7 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSPITAL			e. STREET ADDRESS 10 LAUER TERRACE		
3. NAME OF DECEASED (Type or print) STANLEY BARBOUR FOLTZ			4. DATE OF DEATH MARCH 9 1961		
S SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH MAY 23, 1894	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER (retired)			10b. KIND OF BUSINESS OR INDUSTRY Wash. Post Newspaper		
11. BIRTHPLACE (State or foreign country) ALEXANDRIA, VIRGINIA			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME GEORGE J. FOLTZ			14. MOTHER'S MAIDEN NAME MARY N. BARBOUR		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 577-03-2876		17. INFORMANT MRS. FRANCES E. FOLTZ, 10 Lauer Terrace	
Address Silver Spring, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 581.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Uremia (Acute Renal Failure) 1 week (c) Chronic Cirrhosis of Liver Underlying Diabetes Mellitus Underlying					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1953 to Mar 9, 1961 , that (I) (we) last saw the deceased alive on Mar 9, 1961 and that death occurred at 6:25 P.M. from the causes and on the date stated above.					
22a. SIGNATURE George L. Ball			22b. DATE SIGNED Mar 9, 1961		
22c. PHYSICIAN'S NAME (Type) George L. Ball		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 10620 Georgia Ave. Silver Spring, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/11/61		23c. NAME OF CEMETERY OR CREMATORIAL GEO. WASH. CEMETERY	
23d. LOCATION (City, town, or county) PRINCE GEO. COUNTY, MD.		25a. REC'D BY REGISTRAR DATE MAR 14 '61		25b. REGISTRAR'S SIGNATURE Albert L. Frank	
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Frank, INC.					
ADDRESS SILVER SPRING, MD.					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3265

CERTIFICATE OF DEATH.

M
1. PLACE OF DEATH
a. COUNTY

Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda c. LENGTH OF STAY IN lb
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Suburban Hospital

First Middle

3. NAME OF
DECEASED
(Type or print)

Richard

B

Fox

5. SEX

Male

b. COLOR OR RACE

White

7. MARRIED
WIDOWED

X

NEVER MARRIED
DIVORCED

□

8. DATE OF BIRTH

11/14/96

10a. SOCIAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Salesman

10b. KIND OF BUSINESS OR INDUSTRY

Beatrice Ice Cream Co.

11. BIRTHPLACE (County & State, or foreign country)

Maryland

13. FATHER'S NAME

Enoch Fox

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank, dates of service)

No

16. SOCIAL SECURITY NO

577-07-3141

17. INFORMANT

Hilda A. Fox, wife

Address

same as above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

4/20/61

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Myocardial Infarction

INTERVAL BETWEEN
ONSET AND DEATH

10 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 19

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20d. INJURY OCCURRED While at work Not While at work

20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from **3/17**, 1961, to **11/22**, 1961, that (I) last saw the deceased alive on **3/26**, 1961, and that death occurred at **4:15 P.M.** from the causes and on the date stated above.

22a. SIGNATURE

Dewitt E. DeLawter

M.D.

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22b. DATE SIGNED
3/27/61

22c. PHYSICIAN'S NAME (Type)

Dewitt E. DeLawter, M.D.

22d. ADDRESS **8025 ABERDEEN RD Bethesda, Md**

23a. BURIAL, CREMATION, REMOVAL (Specify)
CREMATION 3/29/61

23b. DATE THEREOF **3/29/61**

23c. NAME OF CEMETERY OR CREMATORIAL

Fort Lincoln Crematory Prince Georges County, Md.

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

S.H. Harris Jr.

ADDRESS

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

MAR 28 '61

Arthur S. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 1, could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3266

CERTIFICATE OF DEATH

03254

1. PLACE OF DEATH o. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 13 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton	
3. NAME OF DECEASED (Type or print) Charles		First Lee	Middle Frazier
4. DATE OF DEATH March 5 1961		Month March	Day 5
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
8. WIDOWED <input type="checkbox"/>		9. DIVORCED <input type="checkbox"/>	10. DATE OF BIRTH March 4, 1961
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Eddie Bain Frazier, Jr.	
14. MOTHER'S MAIDEN NAME Shirley Ann Smith		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO None		17. INFORMANT Hospital records	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 161.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO (d) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/4 1961 to 3/5 1961 , that (I) (we) last saw the deceased alive on 3/5 1961 and that death occurred at 8:15 A.M. From the causes and on the date stated above			
22a. SIGNATURE Richard A. Yates, M.D.		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> 22d. ADDRESS Olney, Maryland	22b. DATE SIGNED 3/5/61
22c. PHYSICIAN'S NAME (Type) Dr. Richard A. Yates, M.D.		23a. BURIAL CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF 3/9/61		23c. NAME OF CEMETERY OR CREMATORIAL County Burial Ground	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	25a. REC'D BY REGISTRAR DATE MAR 10 '61
		25b. REGISTRAR'S SIGNATURE Emmett S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

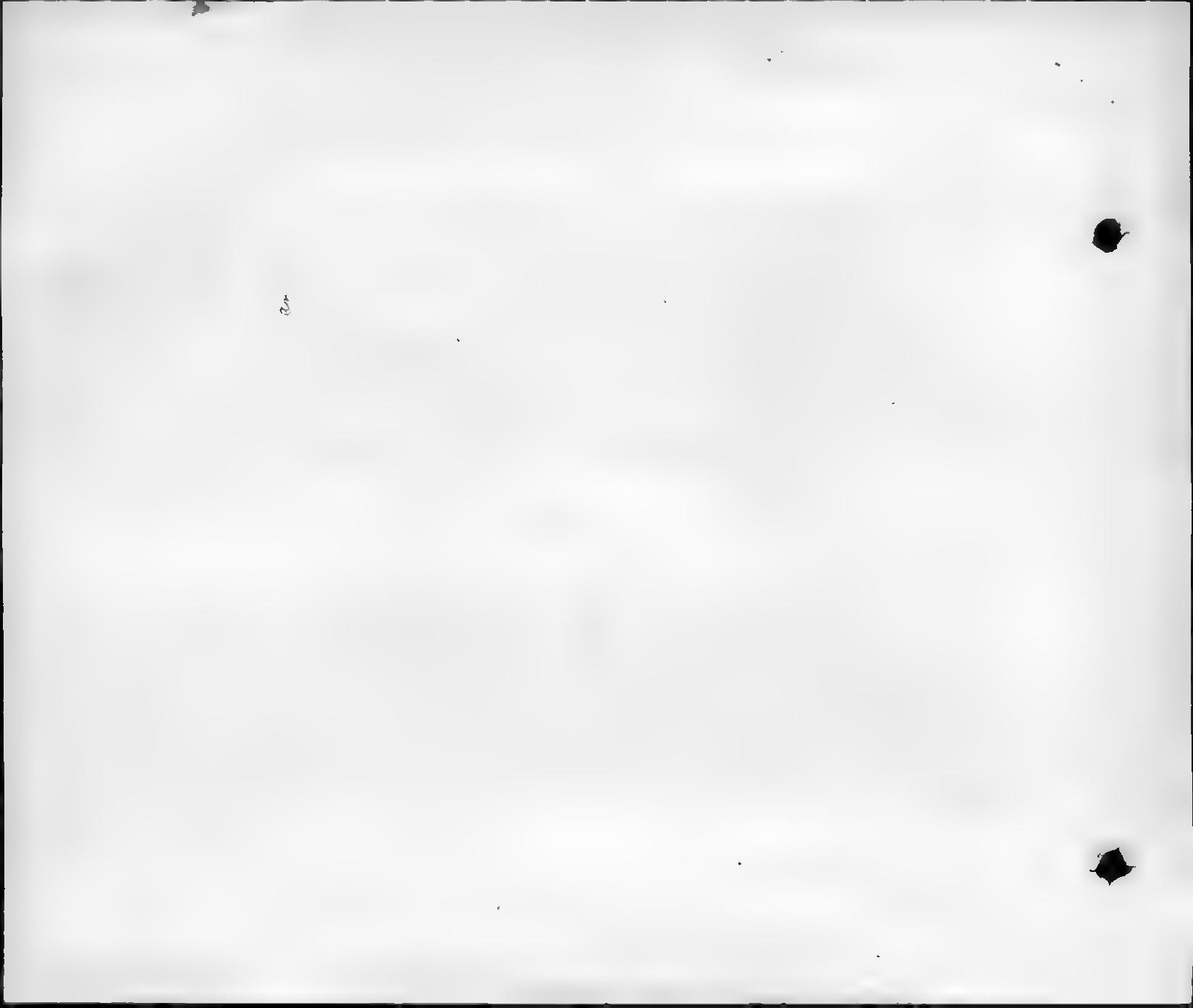
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3267

CERTIFICATE OF DEATH

03255

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 4 days.		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RESNOR Hospital		e. STREET ADDRESS 5416 Bueling Road		f. DATE OF DEATH MARCH 9 1961		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARGARET (N MN) GALLAGHER		First	Middle	Last	Month	Day	Year		
4. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 22, 1875	9. AGE (In years last birthday) 85 yrs.	10. IF UNDER 1 YEAR Months 3 Days 17	11. IF UNDER 24 HRS Hours 5 Min 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Scranton Penna.		12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME JOHN DINSMORE		14. MOTHER'S MAIDEN NAME WATT							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. H. R. GALLAGHER		Address 5416 Bueling Rd. BETHESDA MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		Cause of Death Congestive Heart Failure							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1100		DUE TO (b)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.					
		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH yes					
		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH yes					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month Day Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept. 1957 to March 9, 1961 , that (I) (we) last saw the deceased alive on March 4, 1961 , and that death occurred at 6 A.M. from the causes and on the date stated above									
22a. SIGNATURE Thomas E. Curtin		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/9/61					
22c. PHYSICIAN'S NAME (Type) Thomas E. Curtin		22d. ADDRESS 4600 Connecticut Ave N.W. Wash DC							
23a. BURIAL CREMATION REMOVAL (Specify) Cremation		23b. DATE THEREOF 3/9/61		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory		23d. LOCATION (City, town, or county) (State) Suitland, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE MAR 14 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline			



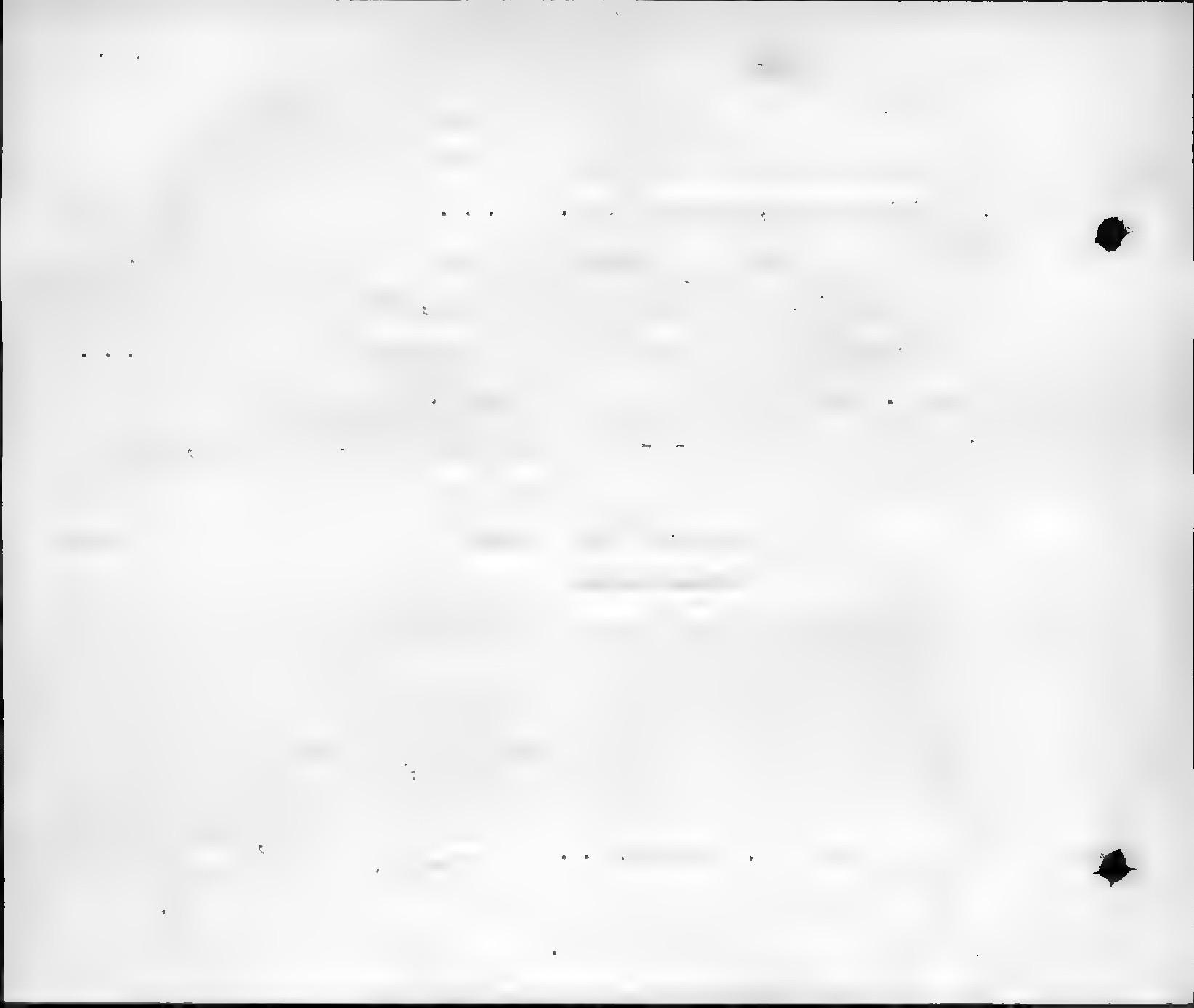
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 2 until it is detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03256

1. PLACE OF DEATH a. CO. / COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 82 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg		d. STREET ADDRESS R.F.D. # 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.							
3. NAME OF DECEASED (Type or print)	First Oswald	Middle Buchanan	Last Garver	4. DATE OF DEATH March 7, 1961	Month March	Day 7	Year 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH January 2, 1911	9. AGE (in years last birthday) 50	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Transportation		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Garver		14. MOTHER'S MAIDEN NAME Mary L. Ford					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 212-09-4327		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4+5/1</i> Conditions if any, which gave rise to immediate cause (a), stating the under- lying cause first		DUE TO (b) DUE TO (c)		Intra-abdominal Hemorrhage Ruptured aortic aneurysm Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Histoplasmosis, disseminated						Hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTO-PSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from December 15, 1960 to March 7, 1961 , that (I) (we) last saw the deceased alive on March 7, 1961 , and that death occurred at 1:45 AM from the causes and on the date stated above.							
22a. SIGNATURE <i>Robert R. Carpenter, MD</i>		M.D. ATTENDING PHYS <input type="checkbox"/>		MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/7/61	
22c. PHYSICIAN'S NAME (Type) Robert R. Carpenter, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland					
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF March 10, 1961		23c. NAME OF CEMETERY OR CREMATORIUM Providence Cemetery		23d. LOCATION (City, town, or county) (State) Carroll County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons		ADDRESS Reisterstown, Md.		25a. REC'D BY REGISTRAR MAR 9 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3269

CERTIFICATE OF DEATH

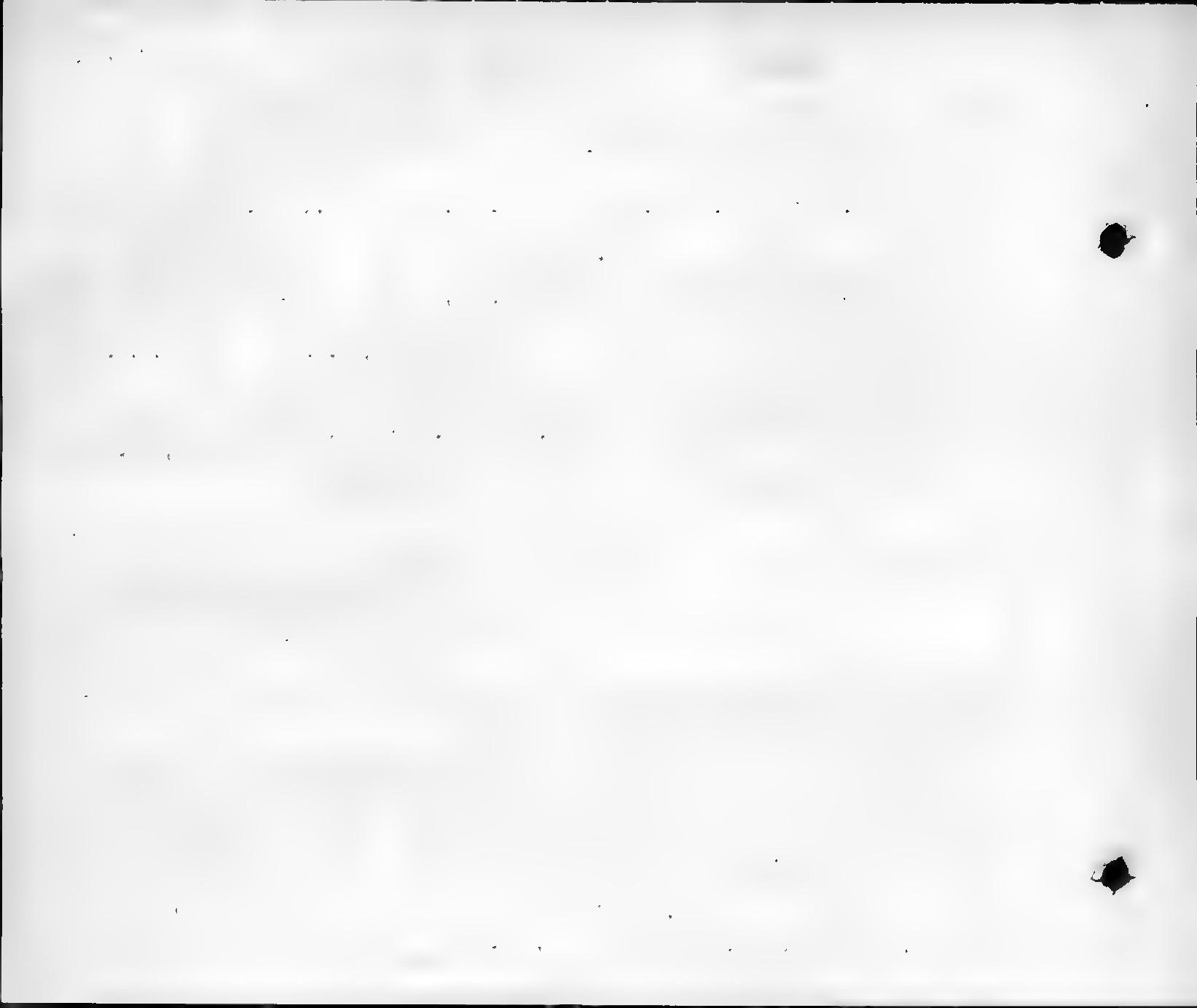
Reg. Dist. No.

03257

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the physician or attending physician, signed by the attending physician and completely filled in by the funeral director, page 1 or 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived if institution residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION 95 E. Wayne Ave., Apt. 412		e. STREET ADDRESS 95 E. Wayne Ave., Apt. 412			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First CAROLYN	Middle L.	Last GASKINS		
4. DATE OF DEATH	Month MARCH	Day 23	Year 1961		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 18, 1885		
9. AGE (In years last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER	10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ALFRED DIOLOT	14. MOTHER'S MAIDEN NAME MARIE LOUISE (UNKNOWN)				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	INFORMANT Mrs. James R. Fryrear, 9702 Dilston Road	Address Silver Spring, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Decompensation</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH 5-6 yrs.					
PART II. OTHERS NOTICABLE CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Metastatic adenocarcinoma of lungs from breast</i>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 9606 Calverton Rd., Silver Spring, Md.	20f. (City or town) 9606 Calverton Rd., Silver Spring, Md.	(County) Silver Spring, Md.	(State) MD
21. I certify that I attended the deceased from 1946 , to 23 March, 1961 , that I last saw the deceased alive on 23 March, 1961 , and that death occurred at 10:20 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>William D. Aud</i>			ADDRESS (Street, city or town, state) 9606 Calverton Rd., Silver Spring, Md.		
PHYSICIAN'S NAME (Type) WILLIAM D. AUD			DATE SIGNED 3/23/61		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3/27/61	22c. NAME OF CEMETERY OR CREMATORIUM ST. JOHN'S CEMETERY	22d. LOCATION (City, town, or county) MONTGOMERY COUNTY, MARYLAND	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond E. Pritchett, Inc.</i>	ADDRESS SILVER SPRING, MD.	24a. REC'D BY REGISTRAR EAR 28 '61	24b. REGISTRAR'S SIGNATURE <i>Charles S. Kress</i>		



1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

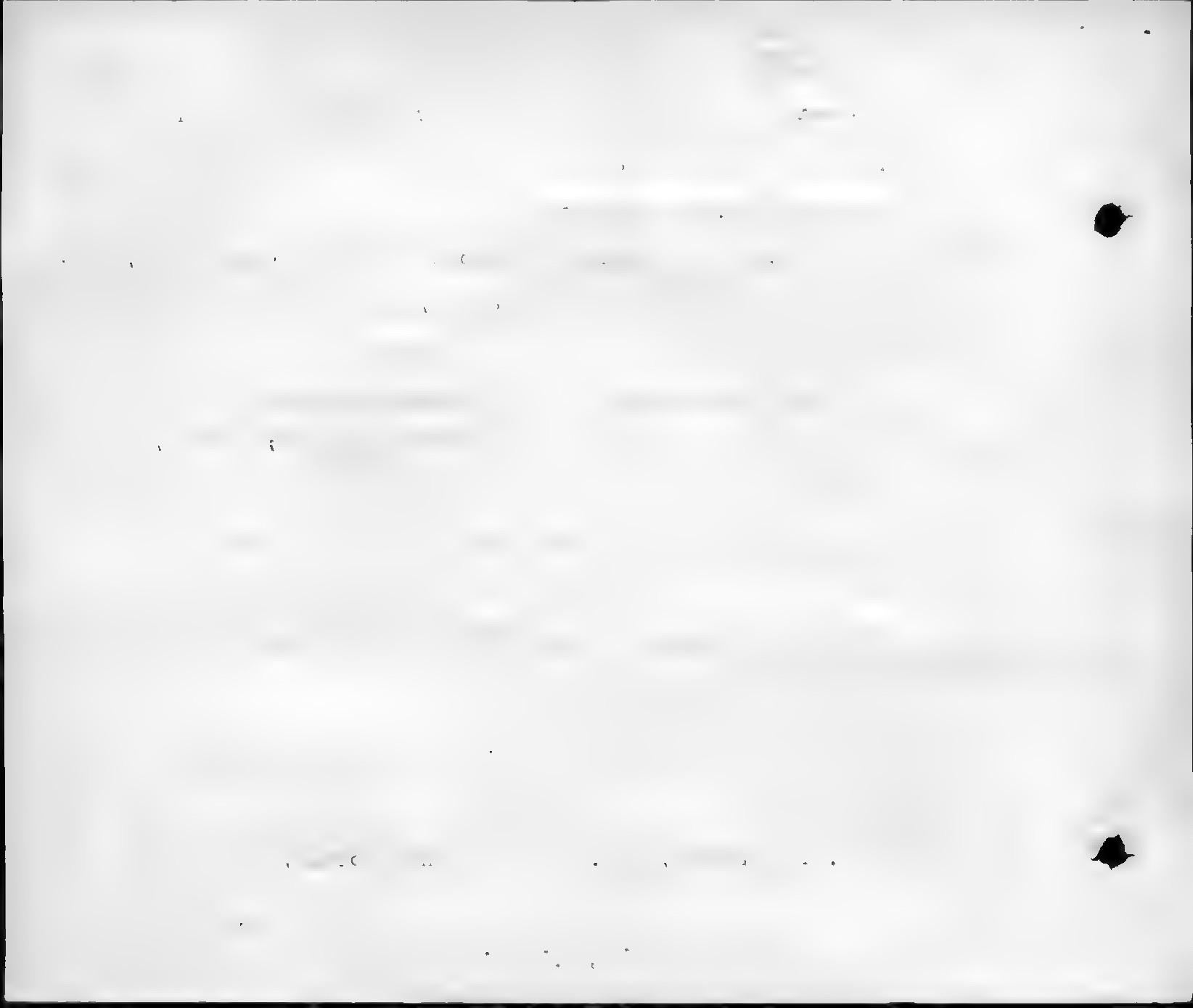
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3270

CERTIFICATE OF DEATH

18258

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN Tb 64 Days		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		f. STREET ADDRESS 1		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital				g. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Rose Morris Gilpin		First Rose	Middle Morris	Last Gilpin	4. DATE OF DEATH March 25, 1961	Month March	Day 25	Year 1961
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 10, 1869	9. AGE (In years last birthday) 91 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	Min. 0
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Frederick Stabler			14. MOTHER'S MAIDEN NAME Martha Brooke					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Hospital Records; Olney, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO 442 X Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last (b) Chronic cardiovascular-renal disease DUE TO (c) Generalized arteriosclerosis								
INTERVAL BETWEEN ONSET AND DEATH 8 days								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fractured femur 2 months ago								
INTERVAL BETWEEN ONSET AND DEATH 5 yr								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Fell at home						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. Aug 30 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Olney	(County) Maryland	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from Aug 30 1961 to Mar 25 1961 , that (I) (we) last saw the deceased alive on Aug 30 1961 , and that death occurred at 102 M , from the causes and on the date stated above								
22a. SIGNATURE A.D. Bonifant		22b. DATE SIGNED Mar 29 1961						
22c. PHYSICIAN'S NAME (Type) A.D. Bonifant, M.D.		22d. ADDRESS Sandy Spring, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/27/61		23c. NAME OF CEMETERY OR CREMATORIAL Friends Meeting House		23d. LOCATION (City, town, or county) Sandy Spring, Maryland		
(State) Md.								
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home		ADDRESS 1331 E Montg. Ave. Rockville, Md.		25a. REC'D BY REGISTRAR Clifford S. Hanna		25b. REGISTRAR'S SIGNATURE Clifford S. Hanna		
DATE MAR 29 '61								



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 will be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3271 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13254

1. PLACE OF DEATH
a. COUNTY

Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Suburban

3. NAME OF
DECEASED
(Type or print)

5. SEX

Female

10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Saleslady

13. FATHER'S NAME

James E. Yates

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war record dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Mary Ann Rebidas

Address 10112 Lewis Dr.

216-30-4937

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

111.3

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (a).

(b)

DUE TO

Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause (b).

(c)

DUE TO

Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause (c).

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m. _____

p.m. _____

19

20d. INJURY OCCURRED Who at work Not who at work

at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion

death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

ACTUAL SIGNATURE *Francis J. Broschart*

EXAMINER'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

3-24-61

22b. DATE THEREOF

Arlington Nat'l.

22c. NAME OF CEMETERY OR CREMATORIAL

ADDRESS

Laytonsville, Md.

23. FUNERAL DIRECTOR

Francis X. Baker

ADDRESS

19

24a. REC'D BY REGISTRAR

MAR 23 '61

24b. REG STAR'S SIGNATURE

Curious S. Francis

DATE

1. PLACE OF DEATH

a. COUNTY

MARYLAND

c. LENGTH OF STAY IN MD

12 hrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Bethesda

3. NAME OF
DECEASED
(Type or print)

First

Middle

4. COLOR OR RACE

White

5. SEX

Female

6. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

7. DATE OF BIRTH

8. BIRTHPLACE (State or foreign country)

9. AGE (In years, months, days)

10. KIND OF BUSINESS OR INDUSTRY

Dry Goods Store

11. BIRTHDAY (Year)

12. CITIZEN OF WHAT COUNTRY?

13. MOTHER'S MAIDEN NAME

Virginia

14. FATHER'S NAME

James E. Yates

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war record dates of service)

No

16. SOCIAL SECURITY NO.

216-30-4937

17. INFORMANT

Mary Ann Rebidas

Address 10112 Lewis Dr.

INTERVAL BETWEEN ONSET AND DEATH

12 hrs.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

111.3

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (a).

(b)

DUE TO

Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause (b).

(c)

DUE TO

Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause (c).

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m. _____

p.m. _____

19

20d. INJURY OCCURRED Who at work Not who at work

at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion

death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

ACTUAL SIGNATURE *Francis J. Broschart*

EXAMINER'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

3-24-61

22b. DATE THEREOF

Arlington Nat'l.

22c. NAME OF CEMETERY OR CREMATORIAL

ADDRESS

19

24a. REC'D BY REGISTRAR

MAR 23 '61

24b. REG STAR'S SIGNATURE

Curious S. Francis

DATE

19

25. IS RESIDENCE ON A FARM?

YES NO

1. PLACE OF DEATH

a. COUNTY

MARYLAND

c. LENGTH OF STAY IN MD

12 hrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Bethesda

1. PLACE OF DEATH

a. COUNTY

Maryland

c. LENGTH OF STAY IN MD

12 hrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Wheaton

1. PLACE OF DEATH

a. COUNTY

Montgomery

c. LENGTH OF STAY IN MD

12 hrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3501 Henderson Ave

1. PLACE OF DEATH

a. COUNTY

Stanley B. Glover (Husband) Damascus Md

INTERVAL BETWEEN ONSET AND DEATH

12 hrs.

1. PLACE OF DEATH

a. COUNTY

Stanley B. Glover (Husband) Damascus Md

INTERVAL BETWEEN ONSET AND DEATH

12 hrs.

1. PLACE OF DEATH

a. COUNTY

Stanley B. Glover (Husband) Damascus Md

INTERVAL BETWEEN ONSET AND DEATH

12 hrs.

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a. COUNTY

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INTERVAL BETWEEN ONSET AND DEATH

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INTERVAL BETWEEN ONSET AND DEATH

12 hrs.

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a. COUNTY

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INTERVAL BETWEEN ONSET AND DEATH

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INTERVAL BETWEEN ONSET AND DEATH

12 hrs.

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INTERVAL BETWEEN ONSET AND DEATH

12 hrs.

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a. COUNTY

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INTERVAL BETWEEN ONSET AND DEATH

12 hrs.

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INTERVAL BETWEEN ONSET AND DEATH

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INTERVAL BETWEEN ONSET AND DEATH

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INTERVAL BETWEEN ONSET AND DEATH

12 hrs.

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a. COUNTY

Stanley B. Glover (Husband) Damascus Md

INTERVAL BETWEEN ONSET AND DEATH

12 hrs.

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a. COUNTY

Stanley B. Glover (Husband) Damascus Md

INTERVAL BETWEEN ONSET AND DEATH

12 hrs.

1. PLACE OF DEATH

a. COUNTY

Stanley B. Glover (Husband) Damascus Md

INTERVAL BETWEEN ONSET AND DEATH

12 hrs.

1. PLACE OF DEATH

a. COUNTY

Stanley B. Glover (Husband) Damascus Md

INTERVAL BETWEEN ONSET AND DEATH

12 hrs.

1. PLACE OF DEATH

a. COUNTY

Stanley B. Glover (Husband) Damascus Md

INTERVAL BETWEEN ONSET AND DEATH

12 hrs.

1. PLACE OF DEATH

a. COUNTY

Stanley B. Glover (Husband) Damascus Md

INTERVAL BETWEEN ONSET AND DEATH

12 hrs.

1. PLACE OF DEATH

a. COUNTY

Stanley B. Glover (Husband) Damascus Md

INTERVAL BETWEEN ONSET AND DEATH

12 hrs.

1. PLACE OF DEATH

a. COUNTY

Stanley B. Glover (Husband) Damascus Md

INTERVAL BETWEEN ONSET AND DEATH

12 hrs.

1. PLACE OF DEATH

a. COUNTY

Stanley B. Glover (Husband) Damascus Md

INTERVAL BETWEEN ONSET AND DEATH

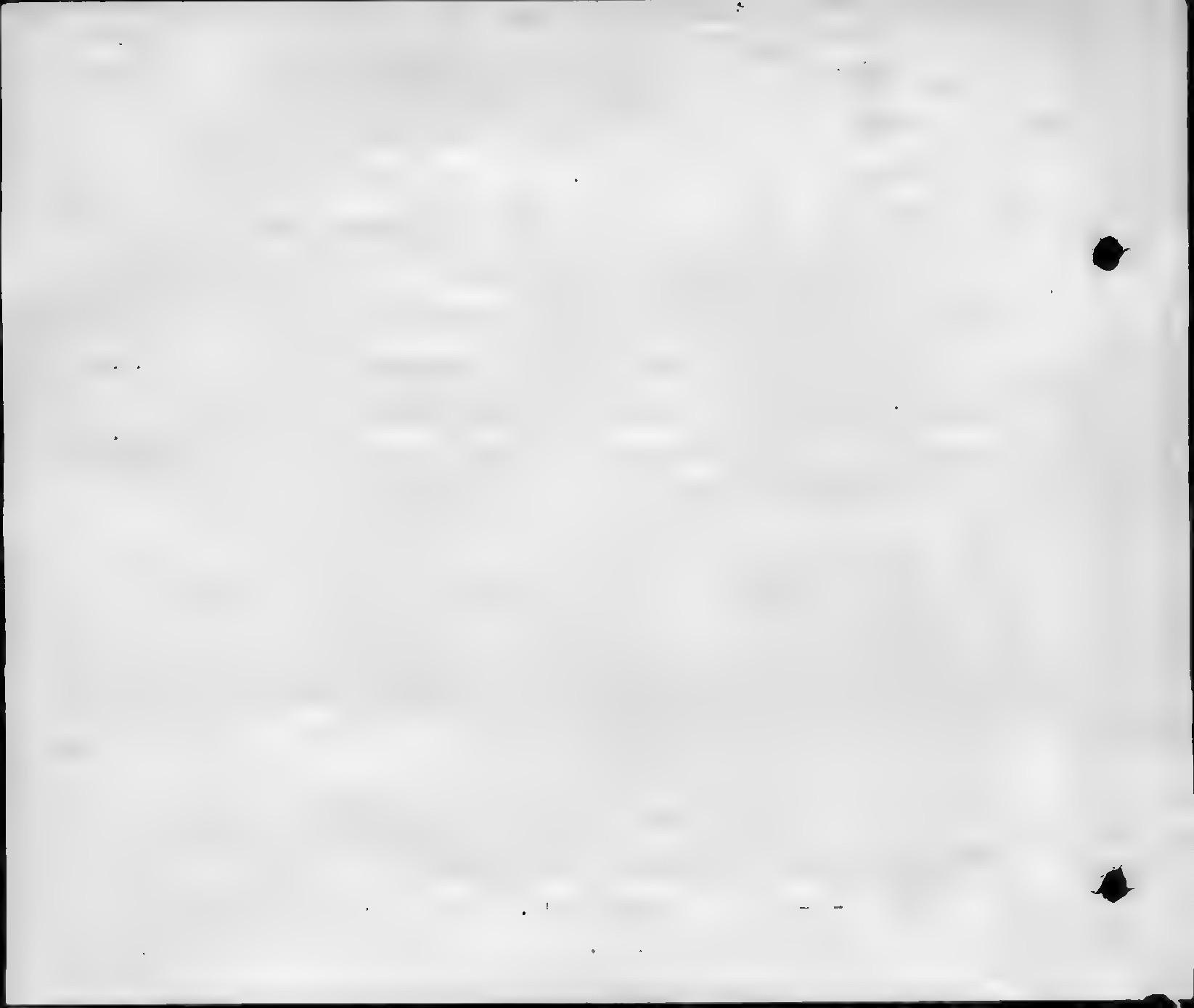
12 hrs.

1. PLACE OF DEATH

a. COUNTY

Stanley B. Glover (Husband) Damascus Md

INTERVAL BETWEEN ONSET AND DEATH



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3272

CERTIFICATE OF DEATH

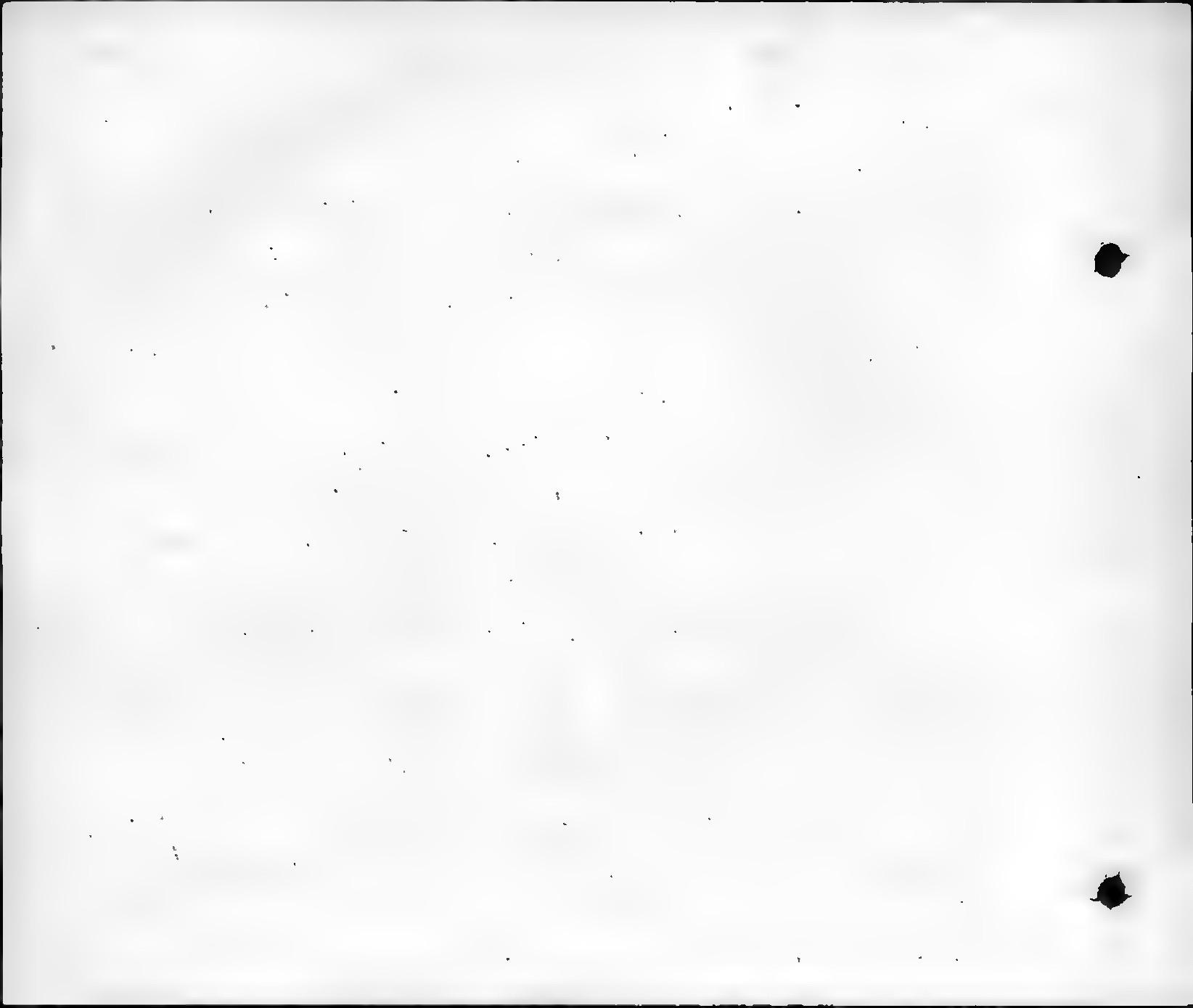
Reg. Dist. No.

13260

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>MONTGOMERY MARYLAND</i>		<i>Maryland Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>RURAL Rockville</i>	<i>6 Mo.</i>	<i>Rural Rockville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
<i>4502 WOOLARK PLACE</i>	<i>4502 WOOLARK PLACE</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
<i>Louis</i>			<i>GOLDBERG</i>
4. DATE OF DEATH	Month	Day	Year
<i>MARCH 13 1961</i>			
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH
<i>Male</i>	<i>WHITE</i>	<i>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></i>	<i>Jan 11 1890</i>
8. AGE (In years lost birthday) yrs	IF UNDER 1 YEAR IF UNDER 24 HRS		
<i>71 yrs</i>	Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<i>FURRIER</i>	<i>MERCHANT</i>	<i>Russia</i>	<i>United States</i>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
<i>AARON GOLDBERG</i>	<i>DEBORAH TEPPER</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>	16. SOCIAL SECURITY NO	INFORMANT	Address
	<i>077-28-4107</i>	<i>Chm J Goldby</i>	<i>4502 Woolark Place</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
<i>Myocardial Infarction</i>			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<i>Generalized Arterio Sclerosis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Hour a. m. p. m.	<i>19</i>	While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from	<i>April 1958</i>	<i>to March 13 1961</i>	that I last saw the deceased alive on <i>March 13 1961</i> , and that death occurred at <i>9 P.M.</i> from the causes and on the date stated above.
ACTUAL SIGNATURE	ADDRESS (Street, city or town, state)		
PHYSICIAN'S NAME (Type)	DATE SIGNED		
<i>JOHN J. CURRY, M.D.</i>	<i>10620 Georgia Ave 3/13/61</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
<i>BURIAL</i>	<i>3-15-61</i>	<i>CEDAR PARK CEMETERY</i>	<i>ORADELL, NEW JERSEY</i>
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a REC'D BY REGISTRAR	24b REGISTRAR'S SIGNATURE
<i>BERNARD DANZANSKY & SONS - 3501-14th St. NW</i>		<i>MAR 15 '61</i>	<i>Arthur S. Krause</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3, to be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

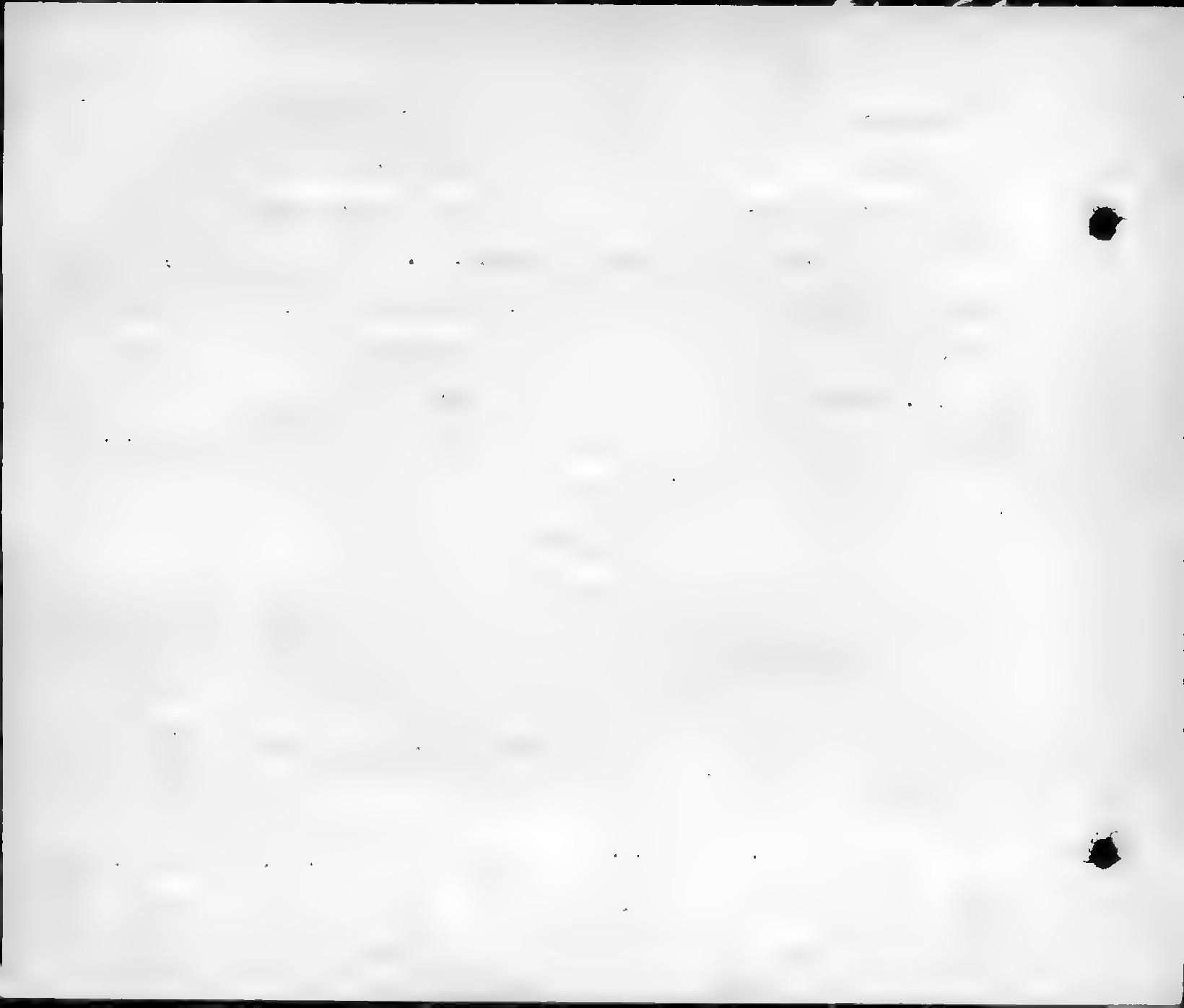
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3273

03261

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE West Virginia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 10 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charleston			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		d. STREET ADDRESS 2505 Cherokee Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First John	Middle Lynn	Last Goshorn, Jr.	4. DATE OF DEATH March 2, 1961	Month March	Day 2	Year 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1915	9. AGE (In years lost birthday) 45 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY Office		11. BIRTHPLACE (State or foreign country) New Mexico		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John L. Goshorn				14. MOTHER'S MAIDEN NAME Jennie Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO.		17. INFORMANT The Medical Record, Address Not Available			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrhythmia DUE TO Metastatic Bronchogenic Carcinoma INTERVAL BETWEEN ONSET AND DEATH 5 Minutes							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO (c)				6 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from February 20, 1961 to March 2, 1961 , that (I) (we) last saw the deceased alive on March 2, 1961 , and that death occurred at 8:40 AM from the causes and on the date stated above.							
22a. SIGNATURE Vincent H. Bono Jr.		M.D.		ATTENDING PHYS <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>	22b. DATE SIGNED 3/2/61
22c. PHYSICIAN'S NAME (Type) Vincent H. Bono		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland					
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-6-61		23c. NAME OF CEMETERY OR CREMATORIAL Springside		23d. LOCATION (City, town, or county) Charleston W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Paul Funeral Home		ADDRESS 4812 Ga Ave NW Wash DC		25a. REC'D BY REGISTRAR EXTE MAR 6 '61		25b. REGISTRAR'S SIGNATURE John S. K.	



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO NURSE DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3276

CERTIFICATE OF DEATH

113262

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Roxburyton

c. LENGTH OF STAY IN lb

37-days-

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

CARROLL HALL 10231 Carroll Place

3. NAME OF
DECEASED
(Type or print)

First Middle

OLIVE

J.

BRAHAM

5. SEX

F

6. COLOR OR RACE

2U

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

OCT. 15-1875

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

At Home

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

North Carolina

13. FATHER'S NAME

John EDMONDSON.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.

(Yes, no, or unknown) (If yes, give rank, dates of service)

NO

17. INFORMANT

NANCY RICKMAN.

Address Same # 1

18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the undying
cause last.

(b)

DUE TO

(c)

Carcinomatous, generalized, primary
site undetermined.

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

19. WAS AUTOPSY
PERFORMED?

YES NO

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While at work Not while at work
p.m. at work

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from March 9, 1961, to March 15, 1961, that (I) (we) last saw the deceased alive on March 9, 1961, and that death occurred at 11 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Blaine H. EIG

22b. DATE
SIGNED

22c. PHYSICIAN'S
NAME (Type)

BLAINE H. EIG

M.D. ATTENDING
PHYS.

MED.
DIRECTOR STAFF
PHYS.

22d. ADDRESS

864 Coleridge Rd Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial 3/18/61

23c. NAME OF CEMETERY OR CREMATORI

Cedar Hill Cemetery

23d. LOCATION (City, town or county)

Prince Georges County, Md. (State)

24 FUNERAL DIRECTOR'S SIGNATURE

The S.H. Hines Co. - 2901 14th St., N.W.

ADDRESS Wash. DC

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE MAR 16 '61

Arthur L. Kline



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

3275

03263

CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town)

Chevy Chase

c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

6822 Delaware Street

**3. NAME OF DECEASED
(Type or print)**

First

Middle

WARREN

WHYTE

4. SEX

male

6. COLOR OR RACE

white

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Attorney

10b. KIND OF BUSINESS OR INDUSTRY

.

8. DATE OF BIRTH

August 2, 1890

70

Yrs.

9. AGE (In years last birthday)

Months

Days

Hours

Min.

11. BIRTHPLACE (County & State, or foreign country)

Alexandria, Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Franklin Pierce Grimes

14. MOTHER'S MAIDEN NAME

Mary Hunter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank, dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

?

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) _____

DUE TO _____

(b) _____

DUE TO _____

(c) _____

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITIONED IN PART I.e.)

19. WAS AUTOPSY PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18, OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While at work Not While at work
p.m. 19 at work

20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/5/58, 19, to 3/5, 1961, that (I) (we) last saw the deceased alive on 3/3, 1961, and that death occurred at 11:45 P.M. from the causes and on the date stated above

22a. SIGNATURE
John A. Reisinger

22c. PHYSICIAN'S NAME (Type)
John A. REISINGER

22b. DATE SIGNED
3/5/61

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.
22d. ADDRESS
901-20th N.W. WASH. D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation 3/8/61

23c. NAME OF CEMETERY OR CREMATORIAL
Fort Lincoln Crematory Prince Georges County, Md.

24 FUNERAL DIRECTOR'S SIGNATURE
The S.H. Hines Co. - 2901 14th St., N.W.
Washington 9, D.C.

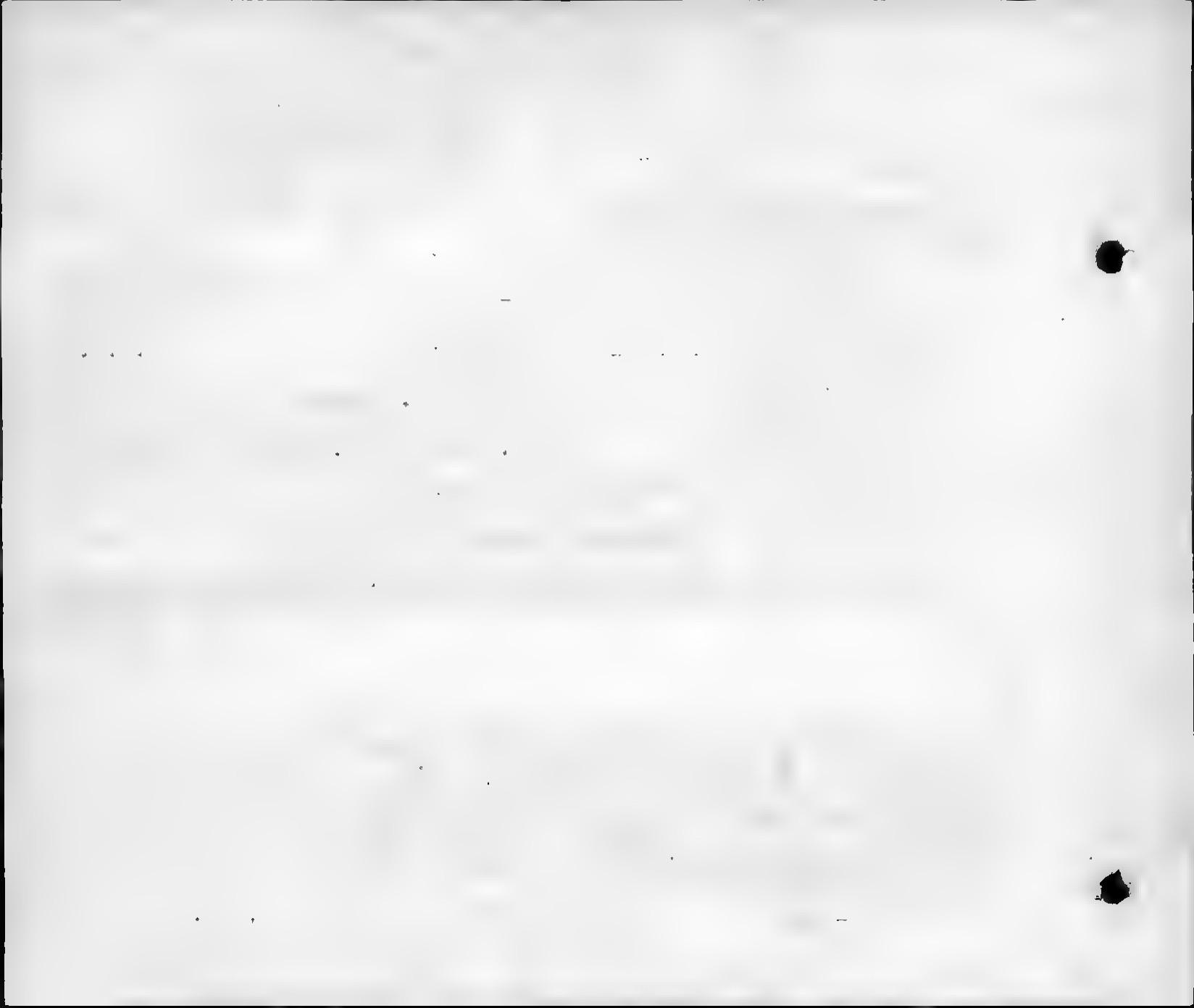
ADDRESS
25a. REC'D BY REGISTRAR MAR 7 '61
25b. REGISTRAR'S SIGNATURE
Arthur L. Kline

1948

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5
in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 5
and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										03264		
3276 CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda					c. LENGTH OF STAY IN 1b - - -					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria		
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Congressional Sanitarium					d. STREET ADDRESS 1622 Fitzgerald Lane					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Lucy	Middle 	Last Gutridge	4. DATE OF DEATH		Month MARCH	Day 23	Year 1961			
5. SEX F		6. COLOR OR RACE LW		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-5-1878		9. AGE (In years less birthday) 82 yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY - - -					11. BIRTHPLACE (State or foreign country) Virginia		
13. FATHER'S NAME Carter Williams					14. MOTHER'S MAIDEN NAME Emily F. Leavitt					12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - - -					16. SOCIAL SECURITY NO. - - -		17. INFORMANT Mrs. Virginia G. Mayers (Daughter)		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.					Heart failure (b) Cerebral vascular accident (c) Generalized arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH 12 hours months years		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)										WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month July	Day 8	Year 1960	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) 801 Veirs Mill Road		20f. (City or town) Rockville, Maryland (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 8 1960 to March 23 1961 that (I) (we) last saw the deceased alive on March 23 1961 , and that death occurred on March 23 1961 P.M. from the causes and on the date stated above										22b. DATE SIGNED		
22c. SIGNATURE G. Bowditch Hunter, Jr. 22c. PHYSICIAN'S NAME (Type) G. Bowditch Hunter, Jr., M.D.					M.D. <input type="checkbox"/> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> 22d. ADDRESS 801 Veirs Mill Road					22b. DATE SIGNED		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 3-27-1961		23c. NAME OF CEMETERY OR CREMATORIAL Western Cemetery			23d. LOCATION (City, town, or county) Baltimore, Md.			(State)		
24. FUNERAL DIRECTOR'S SIGNATURE Joseph G. Hartman, Jr. ADDRESS 1756 Pa. Ave. 911					25a. REC'D BY REGISTRAR MAR 27 '61 DATE					25b. REC'D BY STRAIGHT Arthur S. Hunt		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3277

CERTIFICATE OF DEATH

03265

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Chevy Chase

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

7900 Glendale Rd.

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

James Edward Halley

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

DIVORCED

6/27/78

4. DATE
OF
DEATH

Month
March 17

Day
19
Year
61

9. AGE (In years
last birthday)

82 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

President of Washington Planograph Co.

Virginia

13. FATHER'S NAME

Edward S. Halley

14. MOTHER'S MAIDEN NAME

Mary Blair

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and date of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

578-07-7678 Paul F. Loehler same as #2

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a)

DUE TO

(b)

DUE TO

(c)

DUE TO

(d)

DUE TO

(e)

DUE TO

(f)

DUE TO

(g)

DUE TO

(h)

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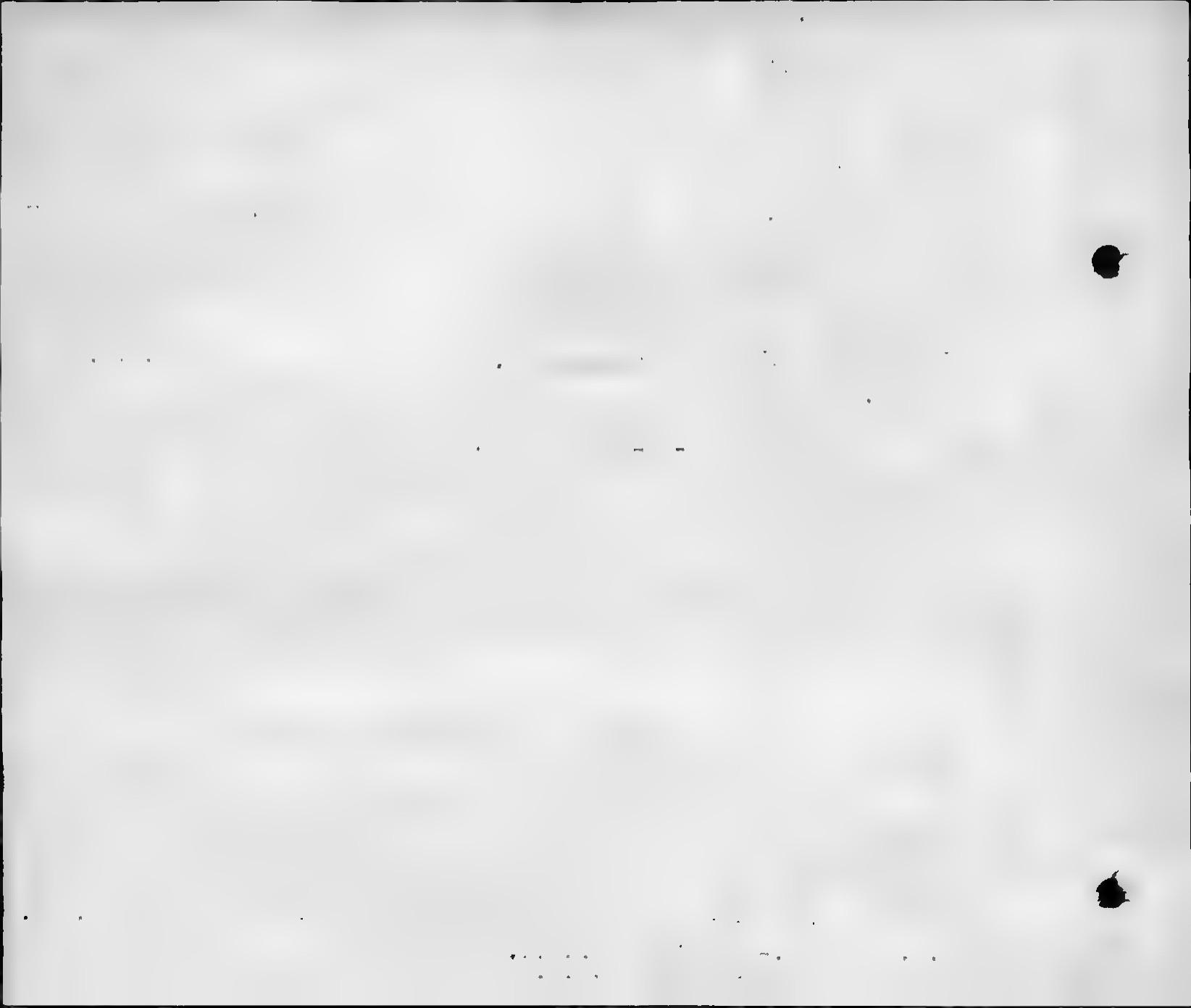
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FOR STATE
HEALTH DEPT.

O DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please initial the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
O FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03266

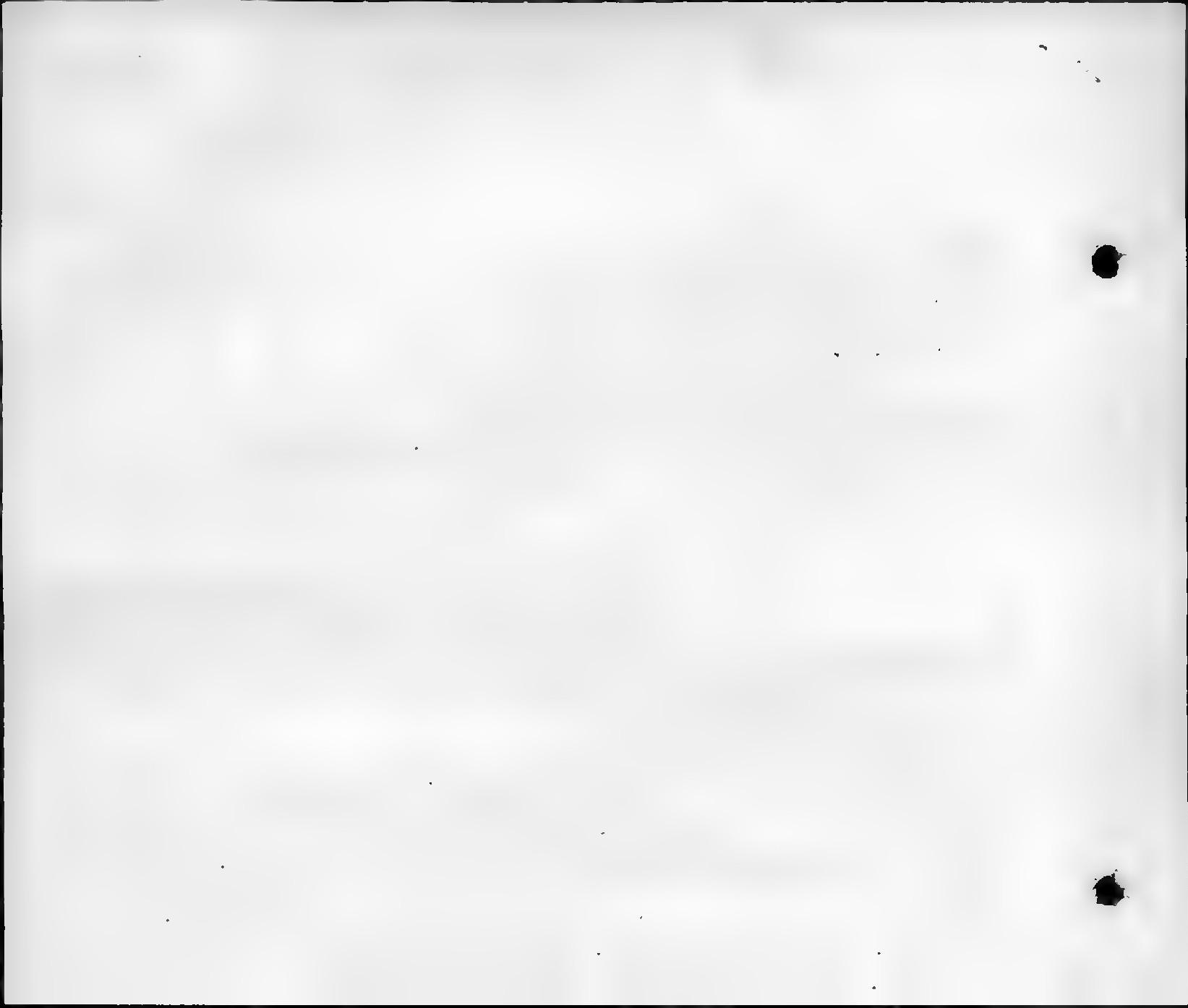
3278 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Mont.		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville	c. LENGTH OF STAY IN lb life	c. CITY OR TOWN (If outsd'a corporate limits, w/r/a RURAL and give nearest town) Rockville		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, g v/a street address) 218 N. Washington St.	d. STREET ADDRESS 218 N. Washington St.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Charles Elias Hammond	First Middle Last	4. DATE OF DEATH Mar. 18, 1961		
5. SEX Male	6. COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/1902	9. AGE (in years) <input type="checkbox"/> IF UNDER 1 YEAR 66 <input type="checkbox"/> Months yrs. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. Hammond	14. MOTHER'S MAIDEN NAME Laggie Giddings	Address Rockville, Md.	INTERVAL BETWEEN ONSET AND DEATH Sudden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or date of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Geo. W. Johnson 222 N. Washington St	18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion	DUE TO (b) DUE TO (c)	PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Rockville, Md.			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Frank J. Broschart	DATE SIGNED Mar. 20, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) 3/27/61	22b. DATE THEREOF 3/27/61	22c. NAME OF CEMETERY OR CREMATORIUM Lincoln Park,	22d. LOCATION (City, town, or country) (State) Rockville, Md.	
23. FUNERAL DIRECTOR Bert L. Surroden	ADDRESS Rockville, Md.	24a. REC'D BY REGISTRAR MAR 30 '61 DATE	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY		3279		Item #3b, #116 G264 4/6/61 iwk				103267						
<i>Montgomery</i>		MARYLAND				Maryland				Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Bethesda		c. LENGTH OF STAY IN lb		2 days		c. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town)		4740 Bradley Boulevard				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		BETHESDA Sanitarium		d. STREET ADDRESS		Chevy Chase		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year						
George		Washington	Harris		April 5 - 1871	89 yrs	11	24	IF UNDER 1 YEAR	IF UNDER 24 HRS				
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	Months	Days	Hours	Months	Days	Min			
Male		White			April 5 - 1871	11	24							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?					
Carpenter						Maryland			H. S.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME												
John Harris		Maria Fish												
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address								
		Yes-Unknown		George J. Harris-son-										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]														
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)														
422.1 Heart Failure														
INTERVAL BETWEEN ONSET AND DEATH 3 years														
DUE TO														
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.														
(b) ASCVD														
DUE TO														
(c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)														
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour o m p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (C'ty or town)		(County)		(State)				
19														
21. I certify that (1) this hospital attended the deceased from 3 June 1961 to 29 March 1961, that (2) (we) last saw the deceased alive on 29 March 1961, and that death occurred at 220 M, from the causes and on the date stated above														
22a. SIGNATURE <i>Robert Young</i>		22b. DATE SIGNED 3/29/61												
22c. PHYSICIAN'S NAME (Type) Robert Young		MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>								
22d. ADDRESS 2500 Calvert St., N.W. Washington 8, D.C.				22d. ADDRESS		2500 Calvert St. N. W. Wash. DC								
23a. BURIAL CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF April 1, 1961		23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery		23d. LOCATION (City, town or county) Washington, D. C.		(State)						
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		25a. REC'D. BY REG. STRR. 4/23 '61		25b. REGISTRAR'S SIGNATURE Anne S. Krause		DATE						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return to the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

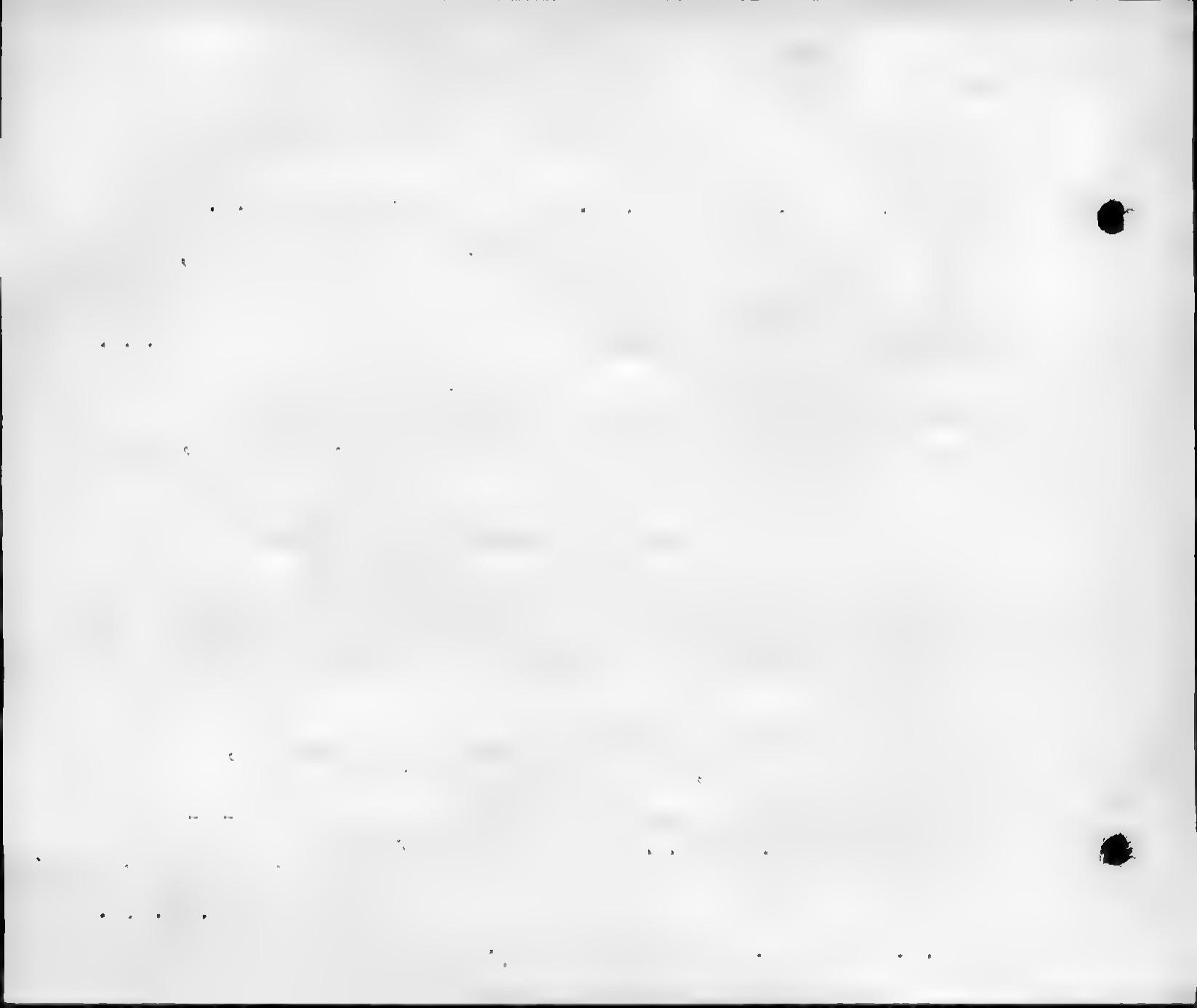
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3280

CERTIFICATE OF DEATH

03268

1. PLACE OF DEATH a. COUNTY Montgomery , MARYLAND			2. USUAL RESIDENCE (Where deceased lived - If institution Residence before admission) a. STATE Virginia b. COUNTY Fairfax						
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 63 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Vienna					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS 916 Cottage Street, S.W.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Ora	Middle Vance	Last Hartbarger	4. DATE OF DEATH March 30,	Month	Day	Year 19 61		
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH October 19, 1923	9. AGE (In years last birthday) 37 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Engineering		11. BIRTHPLACE (State or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Harry Hartbarger			14. MOTHER'S MAIDEN NAME Cleopatra Hughes						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO WW II UNascertainable		17. INFORMANT The Medical Records Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic hereditary nephritis (c)								5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								17 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from January 26, 1961 to March 30, 1961 . That (I) (we) last saw the deceased alive on March 30, 1961 , and that death occurred at 4:55 P.M. from the causes and on the date stated above.								22b. DATE SIGNED 3-30-61	
22a. SIGNATURE Norman H. Bell		M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) Norman H. Bell M.D.		22d. ADDRESS National Institutes Of Health The Clinical Center, Bethesda 14, Maryland							
23a. BURIAL CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 4/1/1961		23c. NAME OF CEMETERY OR CREMATORIUM Hartbarger Cemetery		23d. LOCATION (City, town, or county) Lexington, Va. (R.F.D.#1)			(State)
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		ADDRESS 2901 14th St. N.W. Washington 9, D.C.		25a. REC'D. BY REGISTRAR APR 3 '61		25b. REGISTRAR'S SIGNATURE O. Lewis & Kline			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3281

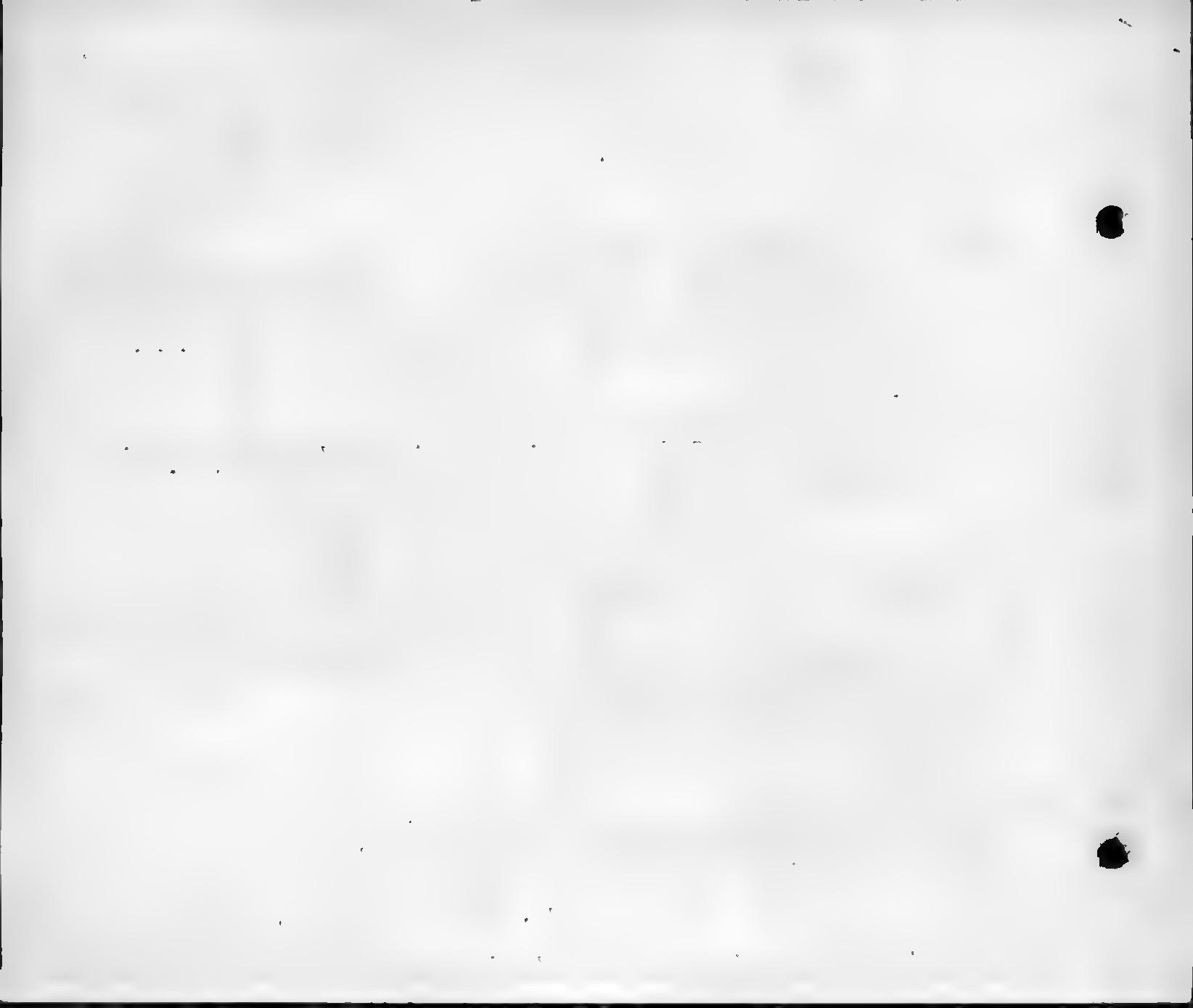
CERTIFICATE OF DEATH

Reg. Dist. No.

03263

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN lb 12 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 215 HILMOOR DRIVE		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
f. STREET ADDRESS 215 HILMOOR DRIVE		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First HARRIE	Middle GAY	Last HASPIN
4. DATE OF DEATH	MARCH	Month 9	Day Year 19 61
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/10/88
9. AGE (In years last birthday) 73 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Salesman (retired)		10b. KIND OF BUSINESS OR INDUSTRY Emerson & Orme Buick	
11. BIRTHPLACE (State or foreign country) WISCONSIN		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME JAMES W. HASKIN		14. MOTHER'S MAIDEN NAME MARIA EMPEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW#1 577-18-7609	
17. INFORMANT Mrs. Nellie R. Haskin, 215 Hillmoor Dr.		Address Silver Spring, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO coronary artery thrombosis & myocardial infarction & resultant congestive failure 12 hrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Generalized arteriosclerotic cardiovascular disease. (c) DUE TO			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1948, 19, to 9 March, 1961, that I last saw the deceased alive on 9 March, 1961, and that death occurred at 6: A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Ernest E. Harmon M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) ERNEST E. HARMON 9301 Colesville Road DATE SIGNED 3/9/61 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 3/13/61 22c. NAME OF CEMETERY OR CREMATORIAL ARLINGTON NAT'L. CEMETERY 22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA			
23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC. Payingne & Dicka		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE MAR 15 '61		24b. REGISTRAR'S SIGNATURE Cathleen J. Kneale	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3282

CERTIFICATE OF DEATH

Reg. Dist. No. 113270

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON		b. COUNTY MONTGOMERY	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11703 JUDSON ROAD		d. STREET ADDRESS 11703 JUDSON ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HOWARD		First	Middle
4. DATE OF DEATH	Month	Day	Year
HAUG	MARCH	27	1961
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 6, 1909
9. AGE (In years last birthday) 51 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0	12. IF UNDER 24 HRS Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. GOVERNMENT EMPLOYEE		10b. KIND OF BUSINESS OR INDUSTRY NEW YORK	
11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FREDERICK DAVID HAUG		14. MOTHER'S MAIDEN NAME FREDA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO INFORMANT RONALD RICH 816 UNIVERSITY BLVD., E. S.S., MD.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			
<i>Coronary oc. myocardial infarct</i> month			
420.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last } (b) <i>Coronary occlusio</i> month			
} DUE TO			
(c) <i>atherosclerosis, coronary</i> 2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
18. INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/15/61</u> to <u>3/27/61</u> , that I last saw the deceased alive on <u>3/26/61</u> , and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Donald Nelson</i>		ADDRESS (Street, city, or town, state) <u>M.D. 10620 Georgia Ave., S.S., MD.</u>	
PHYSICIAN'S NAME (Type) DR. DONALD NELSON		DATE SIGNED <u>3/27/61</u>	
22a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-29-61	
22c. NAME OF CEMETERY OR CHAPEL KING DAVID MEMORIAL GARDEN		22d. LOCATION (City, town or county) FALLS CHURCH, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE BERNARD DANZANSKY & SONS-3501 14th Street, NW		24a. REC'D BY REGISTRAR DATE APR 3 '61	
		24b. REGISTRAR'S SIGNATURE <i>in her S. hands</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3's, to be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3283 11327-1

1. PLACE OF DEATH a. COUNTY <i>Montgomery County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) a. STATE <i>WEST VIRGINIA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>GERMANTOWN MD.</i>	c LENGTH OF STAY IN 1b <i>10.</i>	b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <i>MARYLANDER REST HOME</i>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>PARKERSBURG</i>		
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>EMMA DUDLEY HEATON</i>	First	Middle	Last
4. DATE OF DEATH <i>MARCH 3 1961</i>	Month	Day	Year
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>DEC. 24 1887</i>
9. AGE (In years at birthday) <i>83 yrs</i>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours
13. FATHER'S NAME <i>JOHN W. DUDLEY</i>	14. MOTHER'S MAIDEN NAME <i>EMMA G. LEONARD</i>	15. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT <i>GENERAL Leonard J. HEATON WRANC</i>	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>10 years</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO			
(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>1/15 1961</i> to <i>3/3 1961</i> , that (I) (we) last saw the deceased alive on <i>3/3 1961</i> , and that death occurred at <i>M.</i> from the causes and on the date stated above		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE <i>James P. Kerr</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>3/3/61</i>
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <i>Jamesburg, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>MAR. 6, 1961</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>MOUNT OLIVET</i>	23d. LOCATION (City, town, or county) <i>PARKERSBURG W. Va.</i> (State)
24. FUNERAL DIRECTOR'S SIGNATURE <i>Rinaldi Funeral Home</i>	ADDRESS <i>816 N. H. N.E. DR</i>	25a. REC'D BY REGISTRAR DATE <i>MAR 7 '61</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur J. Davis</i>



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3284

CERTIFICATE OF DEATH

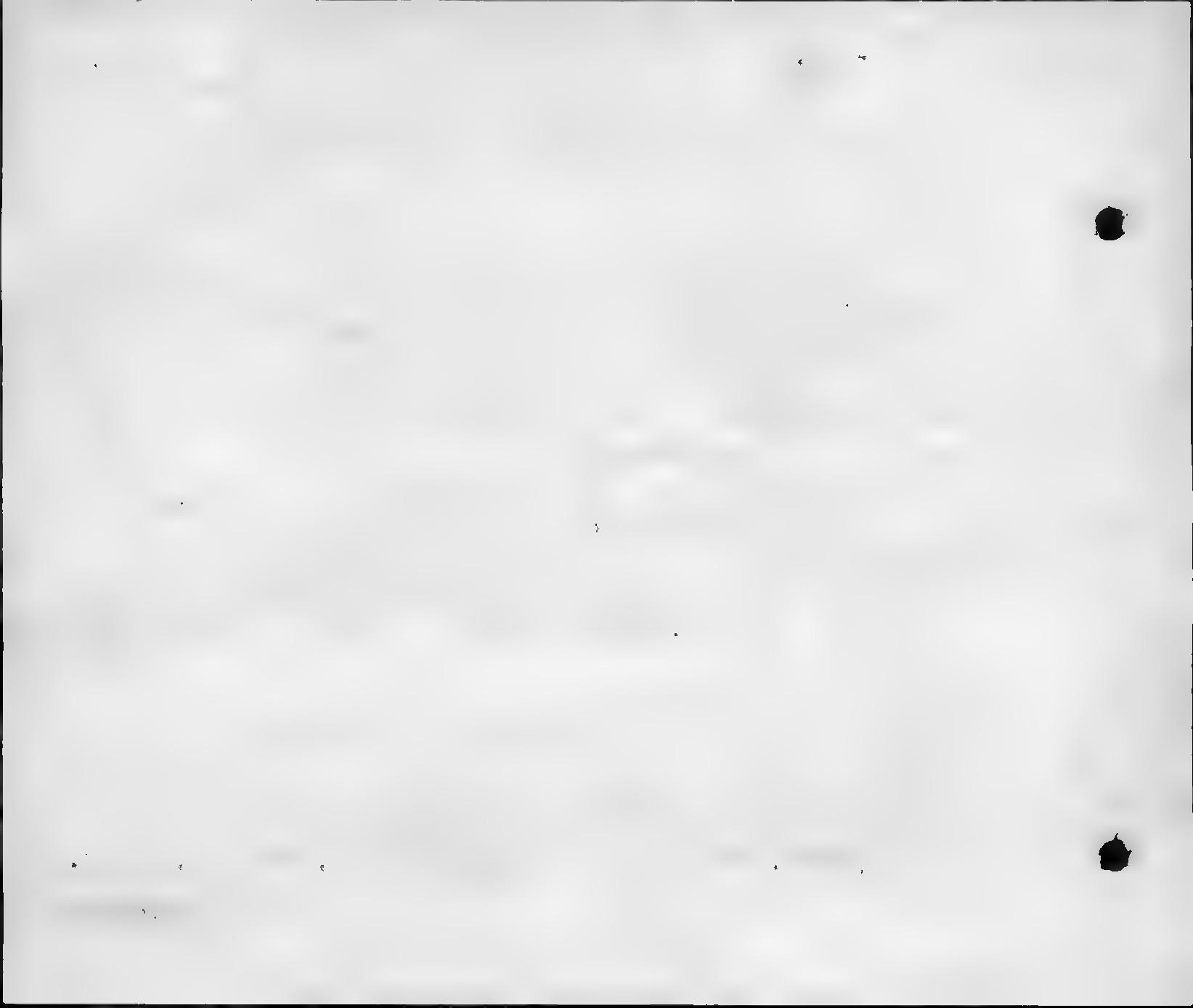
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)	
<i>Montgomery</i>		a. STATE	b. COUNTY
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Towson Park</i>		c. LENGTH OF STAY IN 1b <i>2 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Washington Sanitarium & Hospital</i>		d. STREET ADDRESS <i>426 Pershing Drive</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Nannie Fowler</i>		4. DATE OF DEATH <i>3 - 7 - 1961</i>	Month Day Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>8-5-85</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hhr</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>	9. AGE (In years last birthday) <i>75 yrs.</i>
10c. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		11. IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME <i>Robert Birkhead</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give rank or date of service) <i>No.</i>		16. SOCIAL SECURITY NO. <i>UNKNOWN</i>	17. INFORMANT <i>Hosp Records</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH <i>several days</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary embolism</i>		2 yrs	
DUE TO <i>Adenocarcinoma of lung</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Cerebral hemorrhage from accident</i>			
DUE TO <i>Cerebral hemorrhage from accident</i>			
(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) (If either, notify medical examiner) <i>Car accident</i>			
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED Whila at work <input type="checkbox"/> Not Whila at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>House</i>
20f. (City or town) <i>Falls Church</i>		(County) <i>Falls Church</i> (State) <i>VA</i>	
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 15, 1961</i> to <i>Mar 7, 1961</i> , that (I) (we) last saw the deceased alive on <i>Mar 4, 1961</i> , and that death occurred at <i>7 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Raymond O. West</i>			
22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <i>Raymond O. West</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. 22d. ADDRESS	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> 23b. DATE THEREOF <i>3-13-61</i> 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>FORT. NINETY-EIGHT</i>			
23d. LOCATION (City, town) <i>WASH. D.C.</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph F. Bircher Sons 3034 1/2 st. NW</i>		25a. REC'D BY REGISTRAR <i>Arthur S. Thomas</i>	25b. REGISTRAR <i>Arthur S. Thomas</i>
DATE MAR 14 '61			

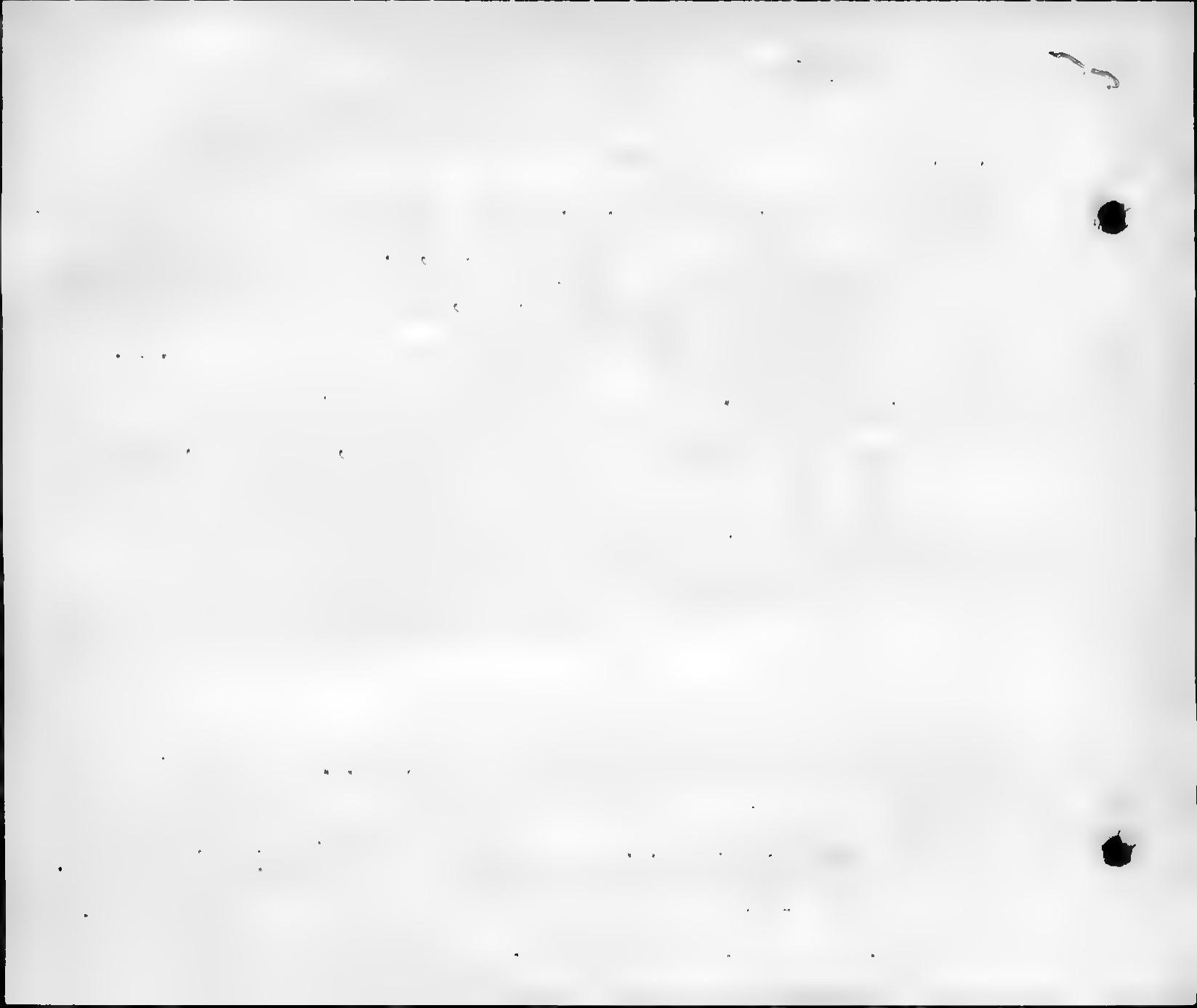


HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERATOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03273

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Pennsylvania		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 70 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Erie		d. STREET ADDRESS 926 West 16th Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Richard	Middle John	Lost Hellman, Jr.	4 DATE OF DEATH March 20, 1961	Month March	Day 20	Year 1961
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 20, 1958		9 AGE (In years last birthday) 2 yrs	10 IF UNDER 1 YEAR Months 2 Days 0 Hours 0 Min 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Richard John Hellman, Sr.				14. MOTHER'S MAIDEN NAME Patricia Shearer				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 199X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Metastatic Ca, Embryonal Cell (c)				Pulmonary Insufficiency		INTERVAL BETWEEN ONSET AND DEATH 5 weeks		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month Day Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from January 9, 1961 to March 20, 1961 . that (I) (we) last saw the deceased alive on March 20, 1961 and that death occurred at 3:45 P.M. The causes and on the date stated above								
22a. SIGNATURE Michael Z. Lazor		M.D.		ATTENDING PHYS <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>	22b. DATE SIGNED 3/20/61	
22c. PHYSICIAN'S NAME (Type) MICHAEL Z. LAZOR, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.				
23a. BURIAL, CREMAT. ON, DATE THEREOF REMOVAL (Specify) Burial-transit 3-21-61		23c. NAME OF CEMETERY OR CREMATORIUM Calvary Cemetery		23d. LOCATION (City, town, or county) Erie, County, Penna.		(State)		
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, Bethesda, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE Mar 23 '61	25b. REGISTRAR'S SIGNATURE Cinton S. House			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

M

1. PLACE OF DEATH
a. COUNTY

Montgomery

b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN 1b

MARYLAND

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington Sanitarium + Hospital

e. FIRST MIDDLE LAST

3. NAME OF DECEASED
(Type or print)

Robert

John

Hook

Mar.

28

1961

4. SEX

Male

white

MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED

9. AGE (In years, if under 1 year, months; if under 24 hrs, hours and minutes)

9/30/82

78 yrs

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Painter

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Penn.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13. FATHER'S NAME

Abraham L. Hook

14. MOTHER'S MAIDEN NAME

Annie Fritz

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give rank and date of service

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Hospital Records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

153.5 DUE TO

Conditions, injury, which
gave rise to immediate cause
(a), storing the underlying
cause last

(b)

DUE TO

(c)

DUE TO

Pulmonary Embolism

Post operative Nectivity

Surgery for Co. Rectosigmoid

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m.20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 27, 1961, to March 28, 1961, that (I) last saw the deceased alive on March 28, 1961, and that death occurred at 9:20 AM, from the causes and on the date stated above

22e. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

22b. DATE SIGNED

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22d. ADDRESS

23e. BURIAL, CREMATION, DATE THEREOF
REMOVED (Specify)

23f. FUNERAL DIRECTOR'S SIGNATURE

23c. NAME OF CEMETERY OR CREMATORIUM

ADDRESS

23d. LOCATION (City, town or county)

(State)

Bladensburg

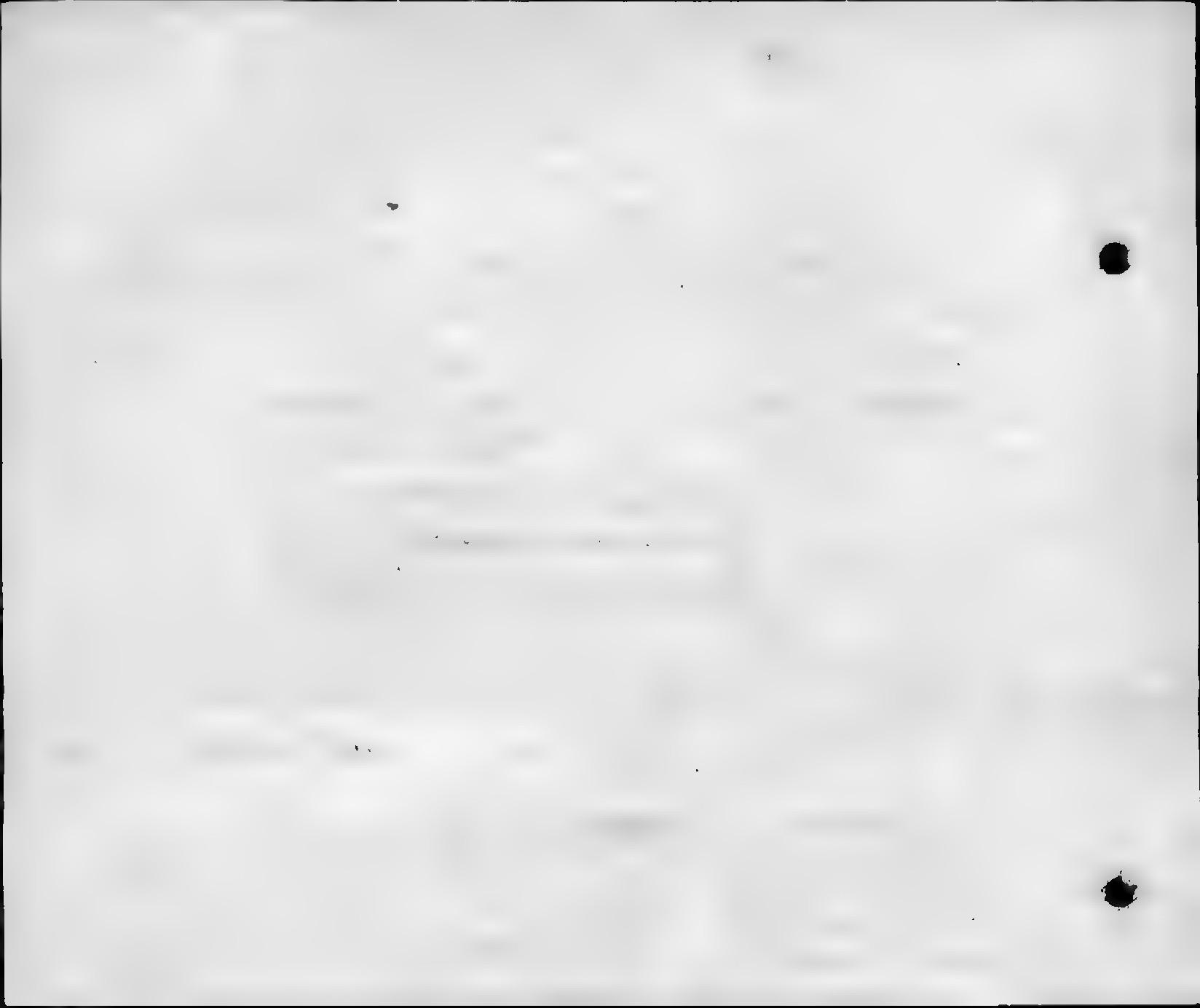
MD.

23e. REC'D BY REGISTRAR

APR 7 '61

23f. REGISTRAR'S SIGNATURE

Arthur S. Kline



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3287

CERTIFICATE OF DEATH

103275

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

MARYLAND

c. LENGTH OF STAY IN lb

7 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Suburban

3. NAME OF
DECEASED
(Type or print)

Mary

First

Middle

Snow Horton

Last

4. DATE
OF
DEATH

Month
March

Day
10

Year
1961

5. SEX

6. COLOR OR RACE

Female

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

13. FATHER'S NAME

George Horton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give rank and date of service

No

16. SOCIAL SECURITY NO.

17. INFORMANT

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Conditions, if any which
give rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

**Septicemia, acute, severe
Hemolytic Staphylococcus
Source undetermined.**

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I.c.)

Arteriosclerosis, generalised.

20d. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m.

20d. INJURY OCCURRED
While at work [] Not at work []

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 1950 to 3.10.1961, that (I) (we) last saw the deceased alive on.... 3.19.1961, and that death occurred at 5:15 P.M. from the causes and on the date stated above.

22e. SIGNATURE

Stewart Clapp

22c. PHYSICIAN'S
NAME (Type)

Stewart Clapp

23b. BURIAL, CREMATION, ETC. DATE THEREOF

REMOVAL (Specify)

Cremation 3/11/1961

23c. NAME OF CEMETERY OR CREMATORIAL

Fort Lincoln Crematory Prince Georges Co. Md.

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

The S.H. Hines Co. 2901 14th St. N.W.
Washington 9, D.C.

ADDRESS

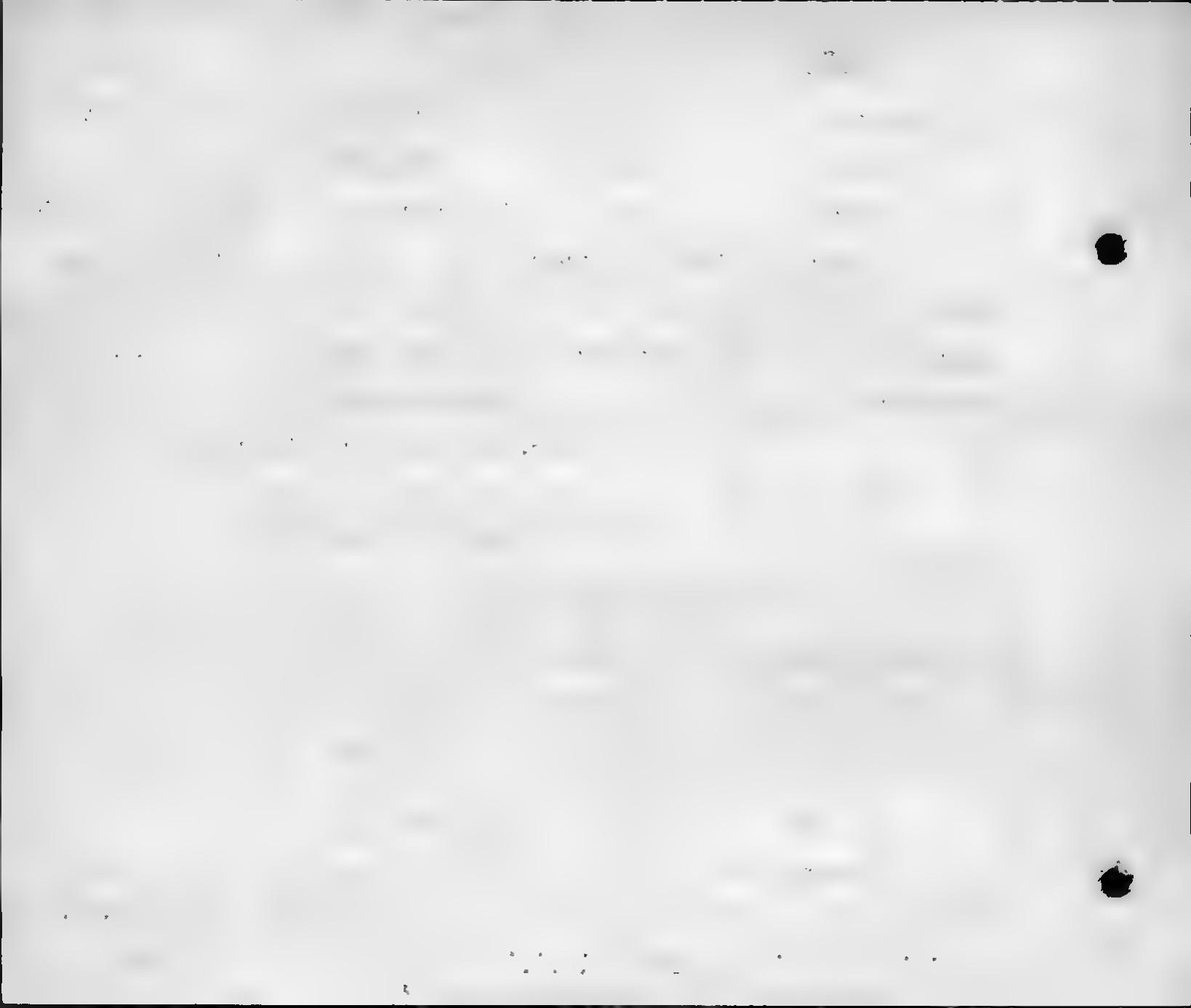
25a. REC'D. BY REGISTRAR MAR 13 '61

DATE

25b. REGISTRAR'S SIGNATURE

Arthur S. Kline

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and countersigned by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3288

CERTIFICATE OF DEATH

03276

1. PLACE OF DEATH
a. COUNTY
Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural)

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
U. S. Naval Hospital

3. NAME OF
DECEASED
(Type or print)

First Middle

Coralee

Theresa

5. SEX

6. COLOR OR RACE

Female

Caucasian

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

Virgil HULSEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Germany

14. MOTHER'S MAIDEN NAME

Barbara WALL

Address _____

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

152X DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

None (F) Virgil Hulsey, same as #2 above

INTERVAL BETWEEN
ONSET AND DEATH
29 days

(b)

DUE TO

(c)

Hydrocephalus, congenital

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from **Feb. 19, 1961** to **March 1, 1961**, that (we) last saw the deceased alive on **March 1, 1961**, and that death occurred at **1:30 AM** from the causes and on the date stated above.

22a. SIGNATURE

Gail A. Magid

22b. DATE
SIGNED
3-1-61

22c. PHYSICIAN'S
NAME (Type)

Gail A. MAGID, LT, MC, USN

ATTENDING
PHYS. MED.
DIRECTOR STAFF
PHYS.

22d. ADDRESS

U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial-Shipment 3-2-61

24. FUNERAL DIRECTOR'S SIGNATURE

Tyson Wheeler
Tyson Wheeler Funeral Home, Rockville, Md.

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS

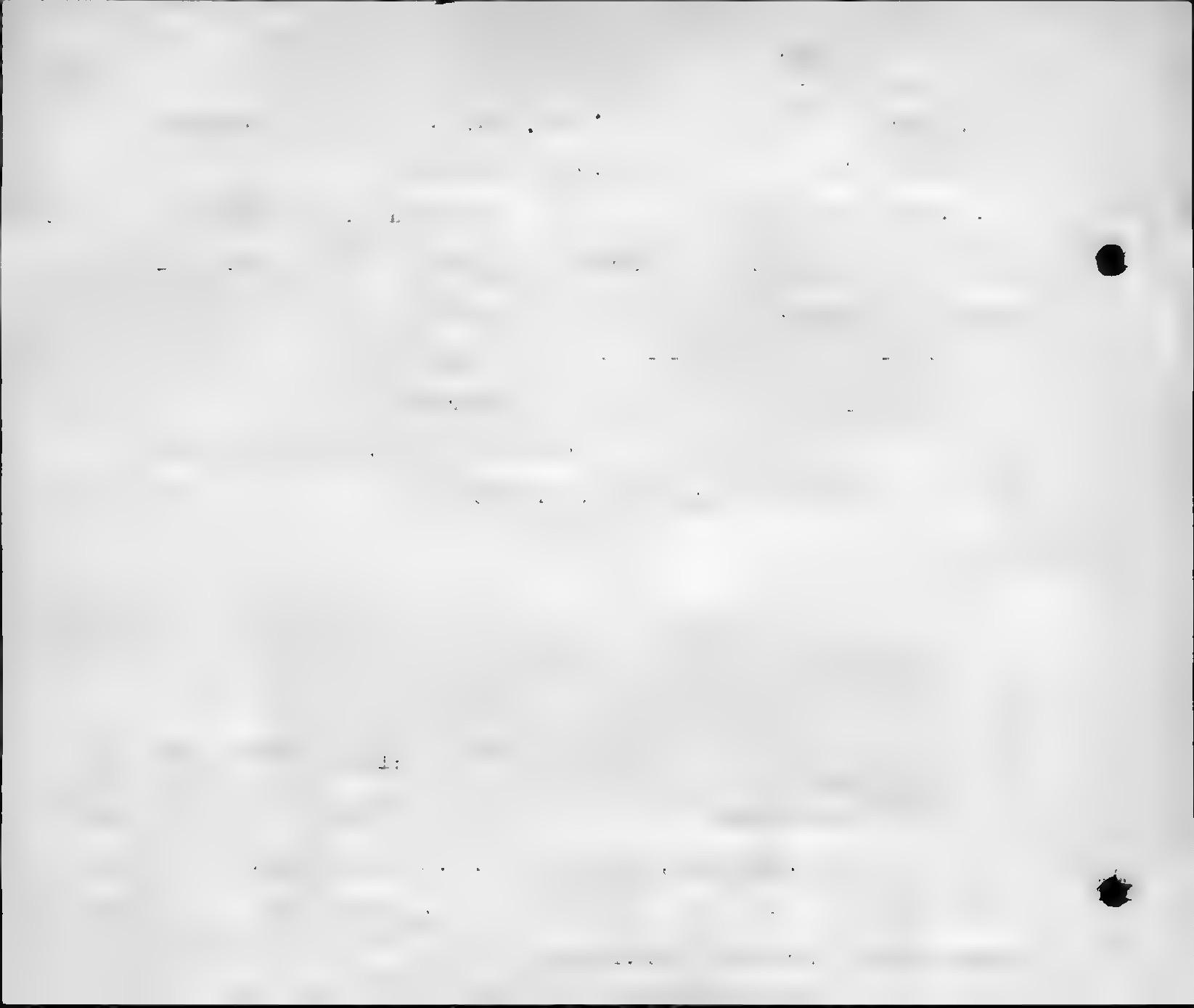
23d. LOCATION (City, town or county) (State)

Tacoma

Washington

25a. REC'D BY REGISTRAR MAR 3 '61

25b. REGISTRAR'S SIGNATURE
Arthur L. Thane



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3289

CERTIFICATE OF DEATH

0327

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

U.S. Naval Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Edward Shillingford HUTCHINSON

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED 8. DATE OF BIRTH

Male

Caucasian

WIDOWED D VORCED

14 February 1904

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE County & State or foreign country

U.S. Navy

13. FATHER'S NAME

Philadelphia, Pa.

14. MOTHER'S MAIDEN NAME

Edward Hutchinson Jr.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Yes No

18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

1420.0

DUE TO

Conditions, if any, which
give rise to immediate cause
(e), stating the underlying
cause last.

(b)

DUE TO

(c)

Acute Pulmonary Edema

Arterio sclerotic heart disease

Clara Shillingford

Catherine Hutchinson 2501 Q St NW Washington

INTERVAL BETWEEN
ONSET AND DEATH

Minutes to hours

MEDICAL CERTIFICATION

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 1920d. INJURY OCCURRED
While Not While
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (this hospital) attended the deceased from March 6, 1961 to March 12, 1961, that (we) last
saw the deceased alive on March 12, 1961, and that death occurred at 10:20 AM from the causes and on the date stated above.

22e. SIGNATURE

K. V. Harshman

M.D.

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. 22b. DATE
SIGNED
3-13-6122c. PHYSICIAN'S
NAME (Type)

Kenneth V. HARSHMAN, LT, MC, USN

U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, DATE THEREOF
REMOVAL (Specify)

Burial

3-15-61

23c. NAME OF CEMETERY OR CREMATORI

Arlington National

23d. LOCATION (City, town or county)

Arlington, Va.

(State)

24. GENERAL DIRECTOR'S SIGNATURE

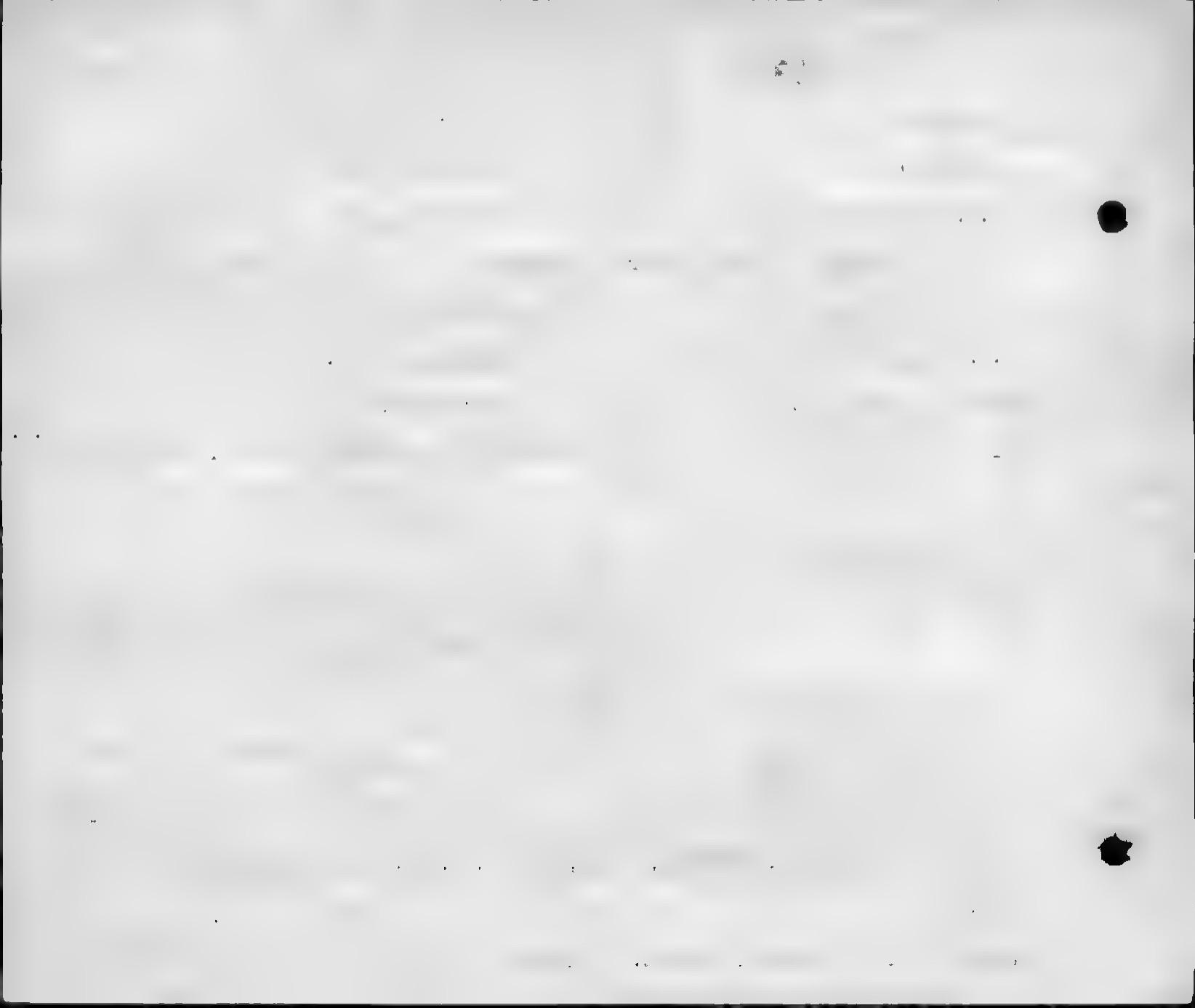
Joseph Gawler's & Sons 1756 Penn. St. NW WDC

ADDRESS

Arlington, Va.

REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE MAR 15 '61 CURTIS S. KRAUS



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the
4 shou
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3290

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13278

1. PLACE OF DEATH

a. COUNTY

Montgomery
Burtsontonville

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN lb

30 yrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Rural

3. NAME OF
DECEASED
(Type or print)

Lawrence Lee Jenkins

First

Middle

Last

4. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

B. DATE OF BIRTH

4-25-1884

76 yrs.

4. DATE
OF
DEATH

Mar 15

Month

Day

Year

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Male white

Owner Florist

13. FATHER'S NAME

John H. Jenkins

14. MOTHER'S MAIDEN NAME

Addie unknown

15. WAS DECEASED EVER IN THE ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

NOTE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

(b)

DUE TO

(c)

4201

Coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH

sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS

PRIMARY OR CONTRIBUTING

CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p m

19

20d. INJURY OCCURRED

While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy

Inspection

Inquiry

and in my opinion

death resulted from.

Natural causes

Accident

Suicide

Homicide

Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

3-15-61

22a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL 3/18/61

22b. DATE THEREOF

ROCK CREEK CEMETERY

22c. NAME OF CEMETERY OR CREMATORIUM

SILVER SPRING, MD.

22d. LOCATION (City, town, or country)

WASHINGTON, D.C.

24a. REC'D BY REGISTRAR

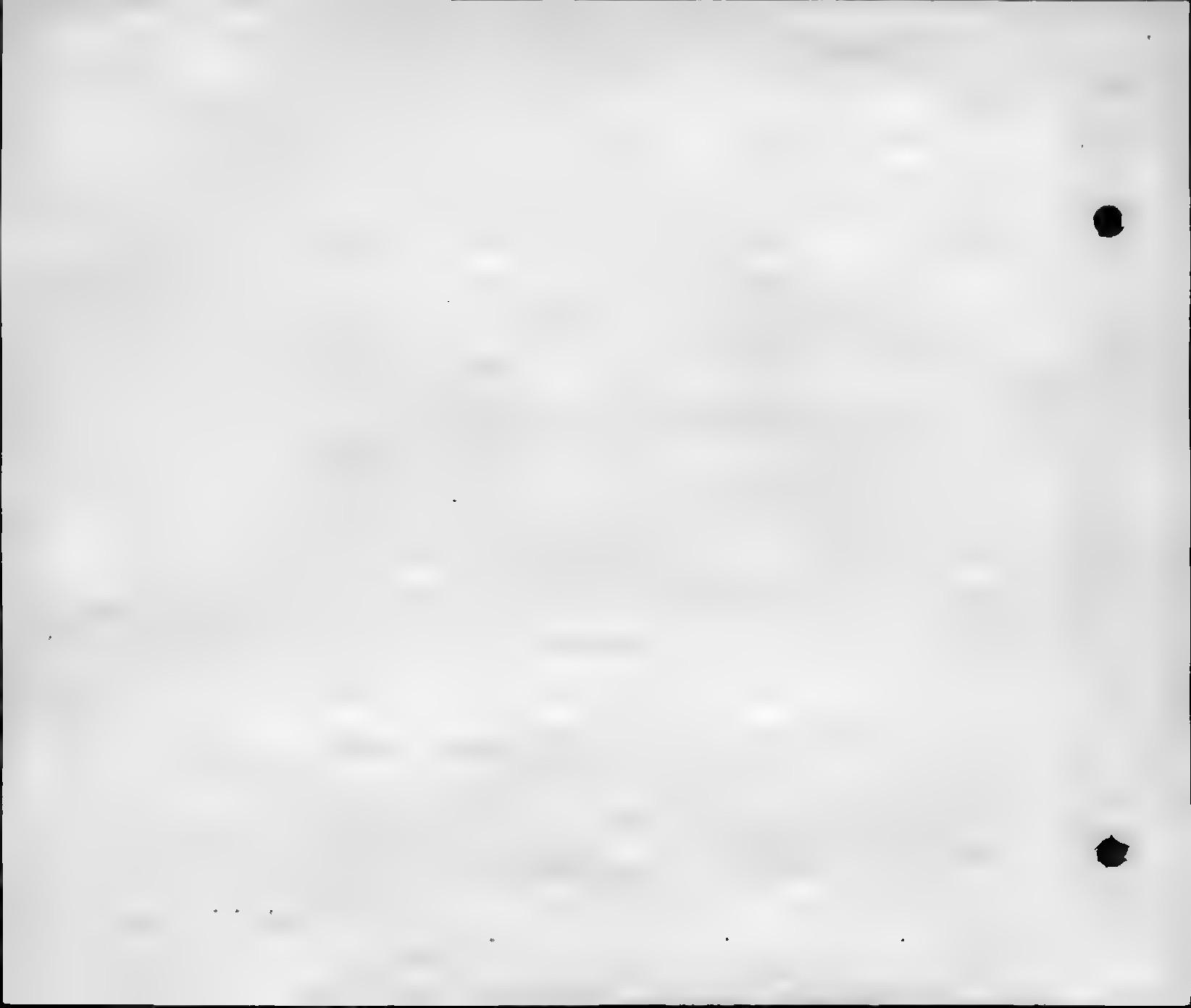
DATE MAR 20 '61

24b. REGISTRAR'S SIGNATURE

Arthur S. Krause

VS. A15ME

SM 7/59



FOR STATE
HEALTH DEPT.

M

1. **STATE MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, execute the certificate, writing the word "pandemic" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03279

1. PLACE OF DEATH

a. COUNTY

MONTGOMERY

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

SILVER SPRING

c. LENGTH OF STAY IN lb

7½ years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

8403 16th St., Apt. 105

3. NAME OF
DECEASED
(Type or print)

First

Middle

RANDOLPH

LEE

JENNINGS

Last

4. DATE
OF
DEATH

MARCH
22

Year
1961

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. MARRIED NEVER MARRIED

WIDOWED

8. DATE OF BIRTH

DEC. 16, 1878

9. AGE (in years
last birthday)

82
yrs.

F UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give x'd of work done during most of working life, even if retired)

CONTRACTOR & BUILDER (RETIRED) OWN BUSINESS

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)
VIRGINIA

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

JAMES T. JENNINGS

14. MOTHER'S MAIDEN NAME

ELLA I. WRENN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

NO

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT

Mrs. Susie E. Jennings, 8403 16th St., Apt. 105
Address
Silver Spring, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH
Found dead
in bed

MEDICAL CERTIFICATION

2d. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

2d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

2d. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

2d. INJURY OCCURRED
While at work Not While at work

2d. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

2d. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL
SIGNATURE

Frank J. Broschart

CHIEF MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S
NAME (Type)

FRANK J. BROSCHEART

ASSISTANT MEDICAL EXAMINER

3/22/61

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

22e. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

22b. DATE THEREOF
3/24/61

22c. NAME OF CEMETERY OR CREMATORIUM

OAK GROVE CEMETERY

22d. LOCATION (City, town, or county)

GLENWOOD, MARYLAND

(State)

24a. FUNERAL DIRECTOR

WINNER E. PIMPUREV, INC.

Raymond J. Giska

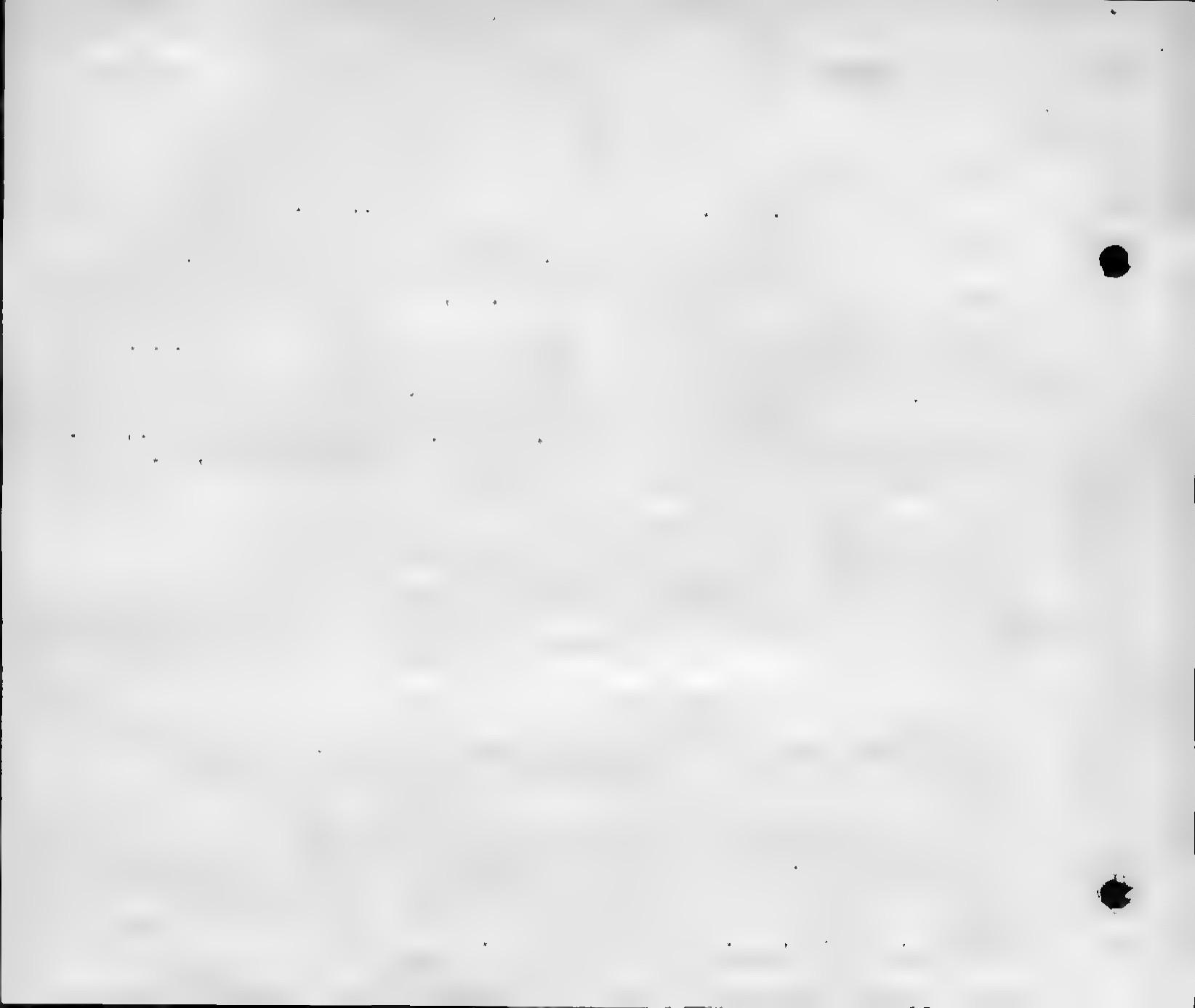
ADDRESS

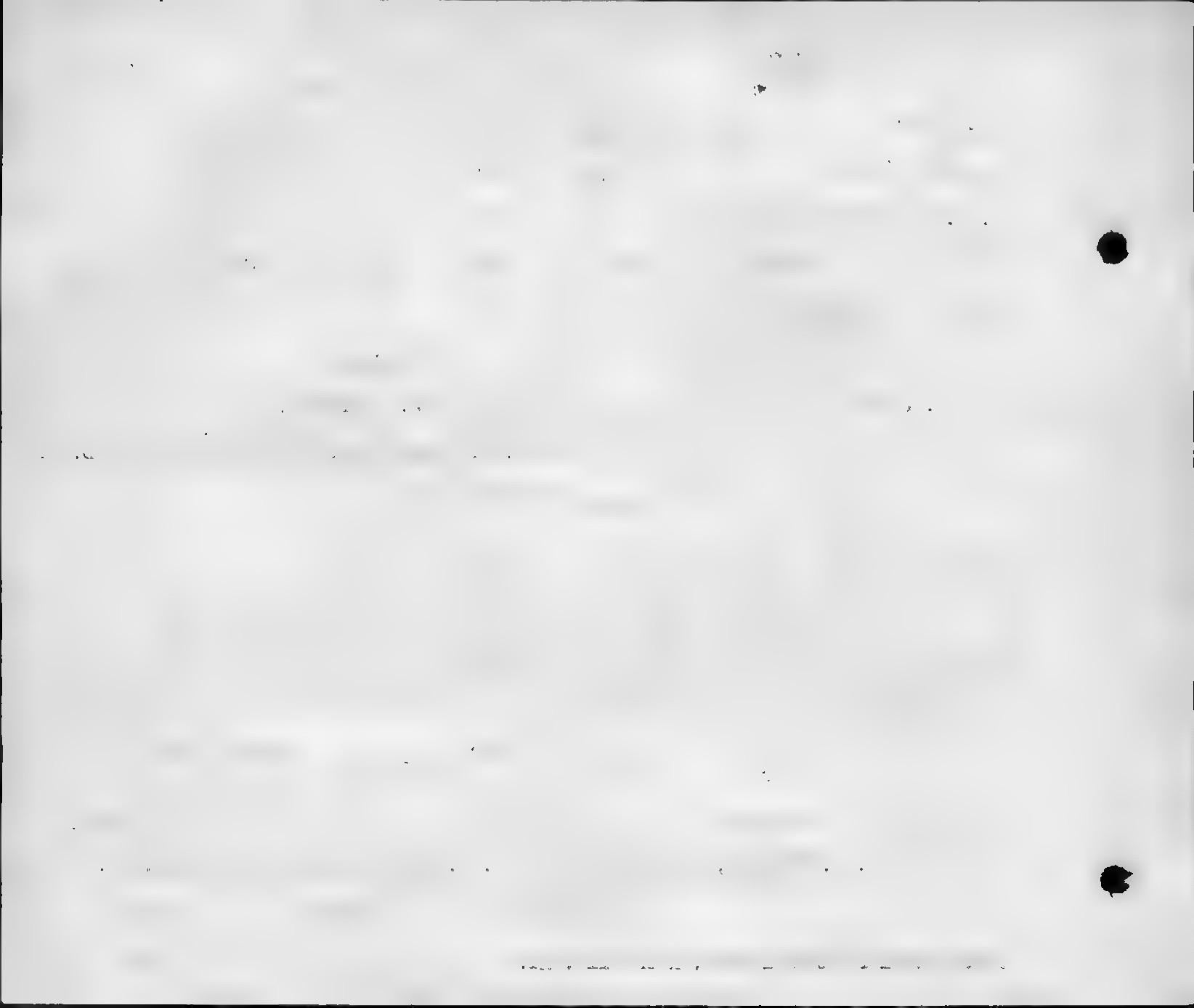
SILVER SPRING, MD.

24a. REC'D BY REGISTRAR

DATE MAR 27 '61

24b. REGISTRAR'S SIGNATURE
Charles S. Kraus





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3293

CERTIFICATE OF DEATH

113281

1. PLACE OF DEATH a. COUNTY		MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE		MARYLAND		b. COUNTY		MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		TAKOMA PARK		c. LENGTH OF STAY IN 1b		6 1/2 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		SILVER SPRING		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		OAKDALE CONVALESCENT HOME		e. STREET ADDRESS		10005 RENFREW ROAD		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH		Month	Day	Year				
PAUL (NMI)		JORDENS		MARCH 24 1961								
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) 83 yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS		
M		W	JUNE 19, 1877									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?						
COOK		MINING CAMPS		CINCINNATI GRAND CAYENNE, OHIO		U.S.A.						
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME										
WILLIAM JORDENS		SARAH STAHR										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOC. SEC. NUMBER		17. INFORMANT		Address						
NO		UNKNOWN		MRS. ROMA PETTINGILL, 10005 RENFREW RD., MD.		SILVER SPRING, MD.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												
117X DUE TO Carcinoma of the prostate with metastases												
INTERVAL BETWEEN ONSET AND DEATH 1 year												
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)												
DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
BRONCHIECTASIS												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
19												
21. I certify that (I) (this hospital) attended the deceased from March 1958 to March 24, 1961, that (I) (we) last saw the deceased alive on March 15, 1961, and that death occurred at 5:45 P.M. from the causes and on the date stated above.												
22a. SIGNATURE		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED March 24, 1961		
BENNET A. PORTER, JR., M.D.												
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		9301 COLESVILLE RD., SILVER SPRING, MD.								
TRNS. & BURIAL 3/29/61		23. NAME OF CEMETERY OR CREMATORIUM		FAIRMOUNT CEMETERY		23d. LOCATION (City, town, or county)		(State)				
						DENVER, COLORADO						
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
RAYMOND E. BURMAN, INC.		SILVER SPRING, MD.		MAR 28 '61		RAYMOND E. BURMAN, INC.						



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3294

CERTIFICATE OF DEATH

03282

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Takoma Park

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington Sanatorium & Hospital

3. NAME OF
DECEASED
(Type or print)

5. SEX

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

13. FATHER'S NAME

George J. Brandt

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)

No

18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)155.8 DUE TO
Conditions, if any, which
gave rise to immediate cause{ (b) } DUE TO
(e), stating the underlying
cause last.

{ (c) }

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month Day Year
Hour a.m. 20d. INJURY OCCURRED
p.m. 19 White Not White
at work at work

21. I certify that (I) (this hospital) attended the deceased from 2/19/61 to 3/25/61, that (I) (we) last saw the deceased alive on 3/25/61, and that death occurred at 10 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Chas H. Holahan
Chas H. Holahan, M.D.23a. BURIAL, CREMATION. 23b. DATE THEREOF
REMOVAL (Specify)

Burial 3/28/61

24. FUNERAL DIRECTOR'S SIGNATURE

Robert A. Pumphrey Bethesda, Maryland

23c. NAME OF CEMETERY OR CREMATORIAL

Parklawn Cemetery

ADDRESS

Bethesda, Maryland

MD ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22d. ADDRESS

500 Underwood St. N. W. Wash. DC

23d. LOCATION (City, town or county) (State)

Rockville, Maryland

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

DATE MAR 28 '61

Arthur S. Traas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

INTERVAL BETWEEN
ONSET AND DEATH

Months

4-5 small

? ?

Part

4-5 small

? ?



FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

103283

1. PLACE OF DEATH 3295

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

c. LENGTH OF STAY IN 1b

5 yrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

22 Manchester Place apt 304

First

Middle

2. USUAL RESIDENCE (Where deceased lived, if institut. or residence before admission)

a. STATE

MD

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

d. STREET ADDRESS

22 Manchester Pl. apt 304

Last

Month

Day

4. DATE
OF
DEATH

Mar 28

1961

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

Elizabeth

Kane

5. SEX

f. COLOR OR RACE

Female White

7. MARRIED NEVER MARRIED

B. DATE OF BIRTH

WIDOWED

DIVORCED

Oct 29 1897

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

housekeeper

IDb. KIND OF BUSINESS OR INDUSTRY

private home

11. BIRTHPLACE (State or foreign country)

Estonia

13. FATHER'S NAME

Theodore Kane

14. MOTHER'S MAIDEN NAME

Julia Ruuter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or rate or service)

NO

16. SOCIAL SECURITY NO

139-26-3537

17. INFORMANT

VALI

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

b.)

DUE TO

(c)

Anti-congestive heart failure

Cardio-renal disease

INTERVAL BETWEEN
ONSET AND DEATH
Found dead
in bed

MEDICAL CERTIFICATION

20e. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH

2db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19

2dd. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

DATE SIGNED

3-28-61

22a. BURIAL, CREMATION,
REMOVAL (Specify)
BURIAL

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

ROCK CREEK CEMETERY

22d. LOCATION (City, town, or county)

WASHINGTON, D.C.

(State)

23. FUNERAL DIRECTOR

WARNER E. BUMPHREY, INC.

Raymond J. Ziska

ADDRESS

SILVER SPRING, MD.

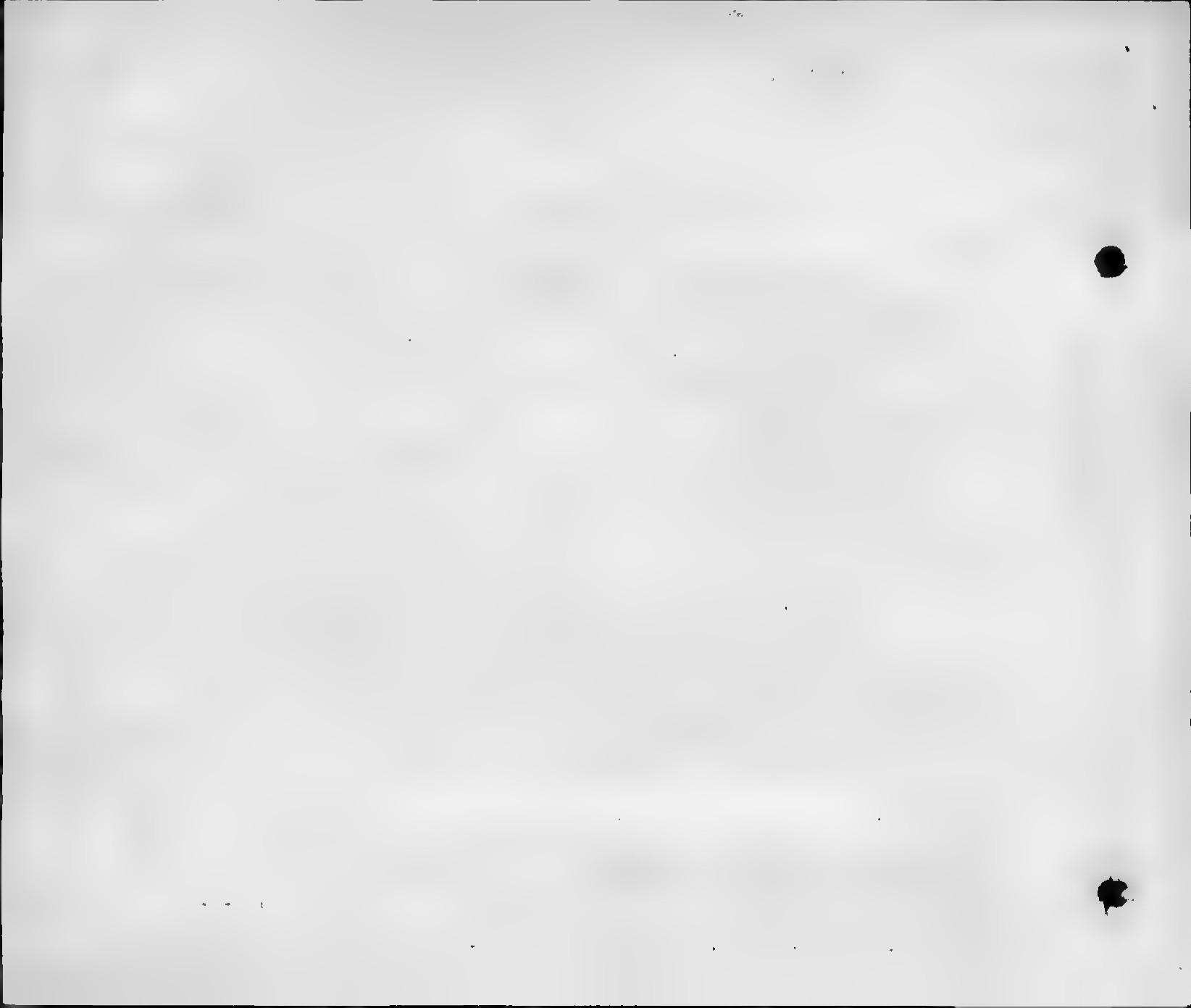
24a. REGISTRAR BY REGISTER

ARTHUR S. THOMAS

DATE

24b. REGISTRAR'S SIGNATURE

Arthur S. Thomas



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be received by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

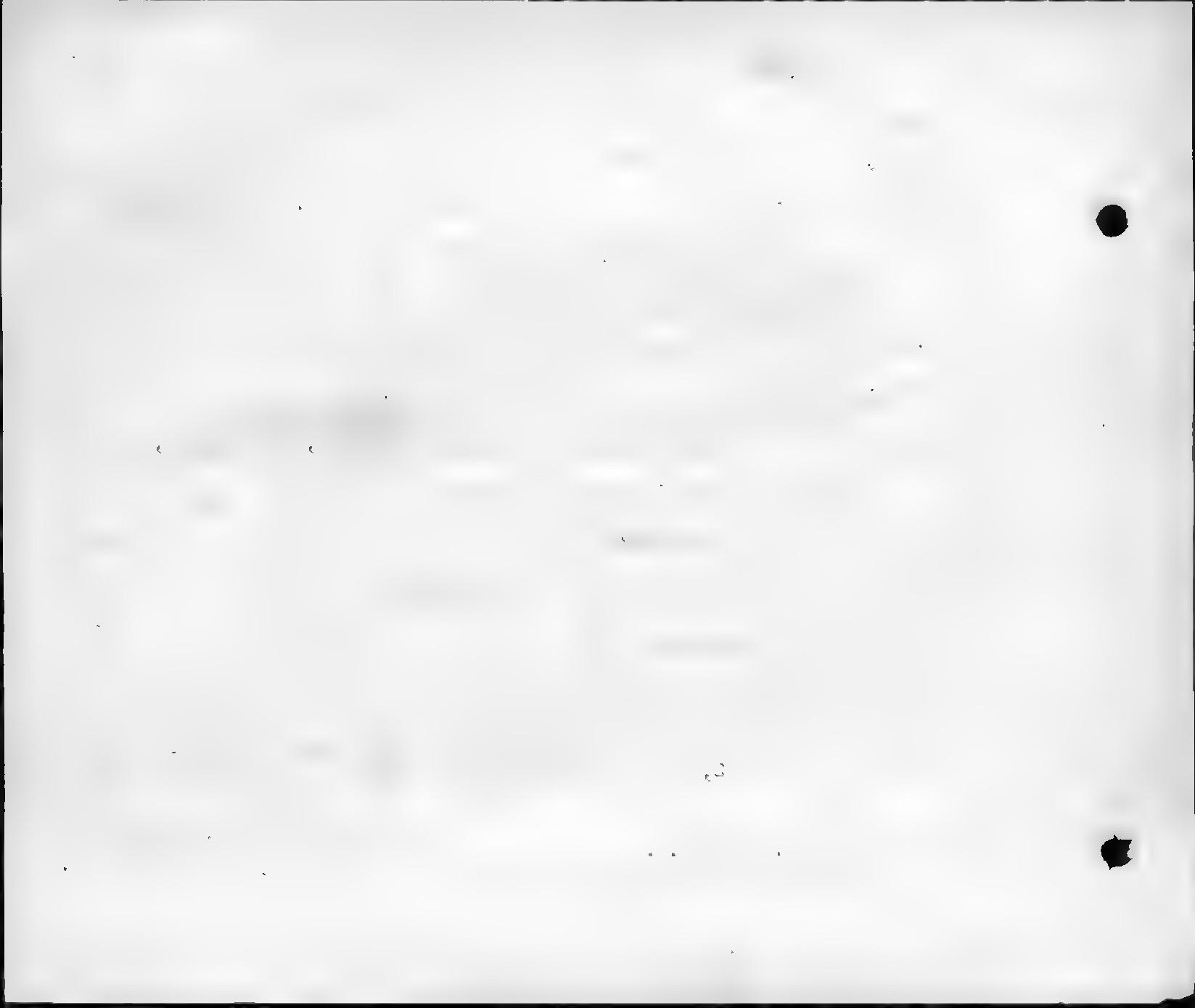
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03284

3296								
1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE New York		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 58 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				d. STREET ADDRESS 218-40 82nd Ave. (Queens Village)		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
3. NAME OF DECEASED (Type or print) Isidore		First	Middle (None)	Last Kassman	4. DATE OF DEATH March 2, 1961	Month March	Day 2	Year 1961
S SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH August 2, 1900	9. AGE (In years last birthday) 60 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fur Merchant		10b. KIND OF BUSINESS OR INDUSTRY Store		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Mordechai Kassman		14. MOTHER'S MAIDEN NAME Emma Feldman						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Not Available		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra Peritoneal hemorrhage		20 Hours						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Thrombocytopenia		4 Months						
(c) Reticulum Cell sarcoma		3 Years						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. January 3, 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from January 3, 1961 , to March 2, 1961 , that (I) (we) last saw the deceased alive on March 2, 1961 , and that death occurred at 1:00PM am the causes and on the date stated above								
22a. SIGNATURE Martin J. Cline		M.D.	ATTENDING PHYS <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>	22b. DATE SIGNED 3/2/61		
22c. PHYSICIAN'S NAME (Type) Martin J. Cline M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.						
23a. BURIAL, CREMATION OR REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-5-61		23c. NAME OF CEMETERY OR CREMATORIUM BETH DAVID CEMETERY		23d. LOCATED (City, town, or county) ELMONTE L.I. N.Y. (State)		
24. FUNERAL DIRECTOR'S SIGNATURE B Danzansky & Sons		ADDRESS 3501-1465777		25a. REC'D BY REGISTRAR DATE MAR 6 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3297

CERTIFICATE OF DEATH

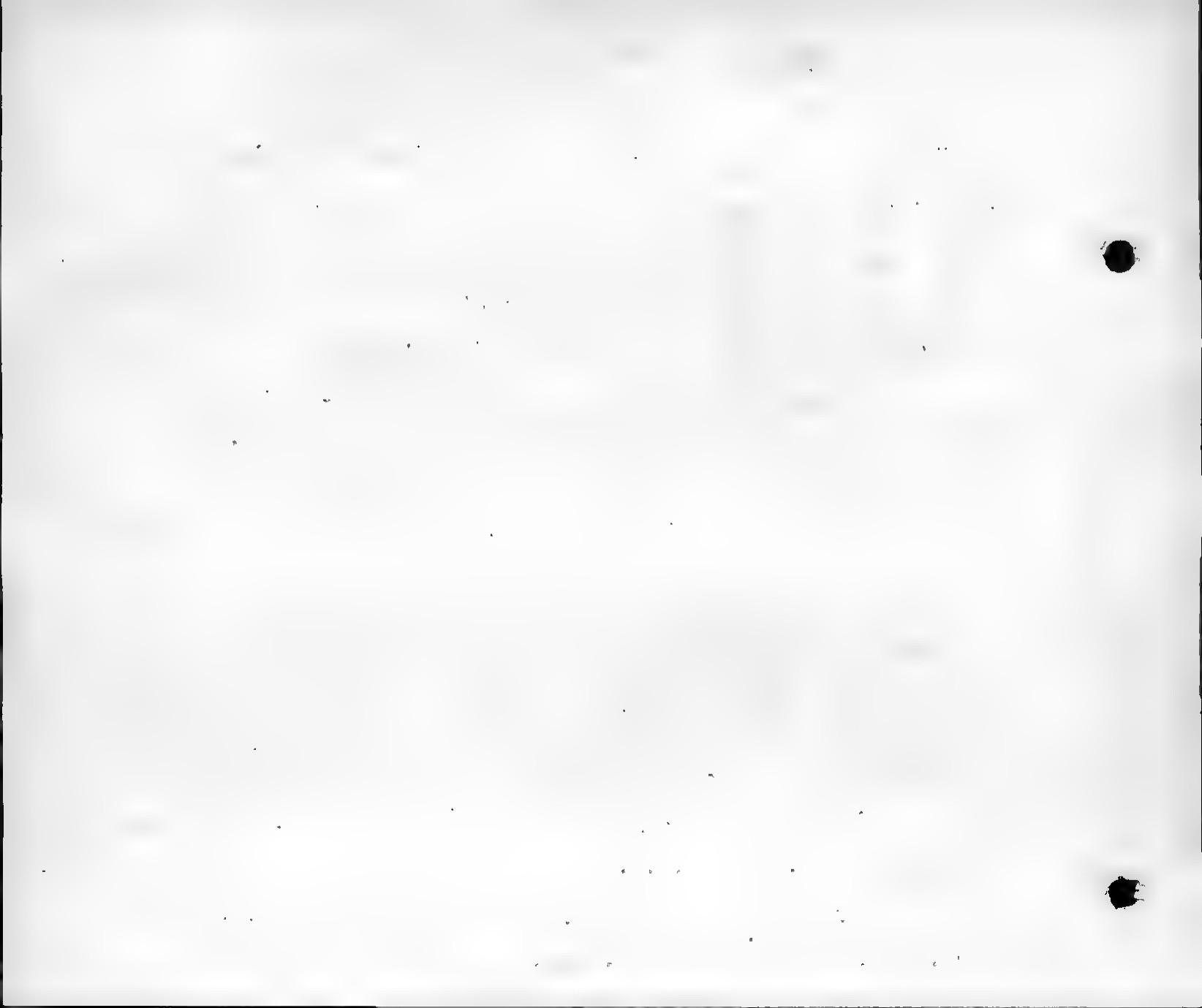
Reg. Dist. No 13285

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN 1b 5 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12608 Valley Wood Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THOMAS		First A	Middle KELEHER
4. DATE OF DEATH March 9, 1961	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1867
9. AGE (In years last birthday) 93 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Entomologist-Dept.of Agriclt		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Keleher		14. MOTHER'S MAIDEN NAME Caroline Trunnell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-28-8607	
		INFORMANT Mary Theresa Motley #2d.	
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			
DUE TO <i>Rupture of arteriosclerotic aneurysm of abdominal aorta</i> 48 hrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteries closes</i> approx. 10-20 yrs			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. — 19 p.m. —		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) — (County) — (State) —	
21. I certify that I attended the deceased from March 9, 1961 , to March 9, 1961 , that I last saw the deceased alive on March 9, 1961 , and that death occurred at 11:15 AM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 8641 Colesville Road, Silver Spring, Md			
DATE SIGNED March 9, 1961			
ACTUAL SIGNATURE <i>Ralph F. Patton</i>		PHYSICIAN'S NAME (Type) Ralph F. Patton, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-11-61	
22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James Ryan Jr.</i>		ADDRESS 317 Penna. Ave., SE	
24a. REC'D BY REGISTRAR Mar 13 '61		24b. REGISTRAR'S SIGNATURE <i>Carlton S. Thomas</i>	



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3298

CERTIFICATE OF DEATH

Reg. Dist. No. 03286

M

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	c. LENGTH OF STAY IN lb <i>2 mo.</i>	d. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring, Md.</i>	b. COUNTY <i>Montgomery</i>
d. NAME OF HOSPITAL (If not in Hospital, give street address) OR NURSING HOME <i>Althea Wallison Nursing Home</i>		d. STREET ADDRESS <i>8813 Glenville Rd.</i>	
3. NAME OF DECEASED (Type or print)	First <i>ROSE</i>	Middle <i>ALICE</i>	Last <i>KERR</i>
4. DATE OF DEATH	Month <i>MARCH</i>	Day <i>25</i>	Year <i>1961</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-11-69</i>
9. AGE (In years last birthday) <i>92 yrs</i>	10. IF UNDER 1 YEAR Months <i>92</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>PENNSYLVANIA</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>
13. FATHER'S NAME <i>Andrew J. Paddock</i>	14. MOTHER'S MAIDEN NAME <i>Mary Lauck</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Horace J Kerr 8813 Glenville Rd S.S.</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>March</i> , 19 <i>59</i> , <i>3/25</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>3/24</i> , 19 <i>61</i> , and that death occurred at <i>3:30</i> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>A.F. Thibadeau</i> PHYSICIAN'S NAME (Type) <i>A.F. THIBADEAU</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-28-61</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Franklin</i>	22d. LOCATION (City, town, or county) (State) <i>Penns.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Deal Funeral Home</i>	ADDRESS <i>4812 Ga Ave NW</i>	24a. REC'D BY REGISTRAR DATE <i>MAR 27 '61</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar.



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3299

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03287

1. PLACE OF DEATH
a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits,
write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN lb

15 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington Sanitarium & Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

Female

white

10a. USUAL OCCUPATION (Give kind of work
BOOKKEEPER working full time, even if retired)

housewife

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED

6/30/92

9. AGE (in years) IF UNDER 1 YEAR
last birthday Months Days Hours Min.

68 yrs

Months

Days

Hours

Min.

13. FATHER'S NAME

Anton Riester

Elizabeth ~~Hochschart~~ Ochsenhirt

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO

(Yes, no, or unknown) (If yes give war or dates of service)

17. INFORMANT

none

Hospital records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Pulmonary thrombosis

INTERVAL BETWEEN
ONSET AND DEATH
sudden

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Fracture of right patella

15 days

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY
PERFORMED?
YES NO

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 10:30
p.m. 29/26/61

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldgs., etc.)
at work home

20f. (City or town)

(County)

(State)

Hyattsville, PG

Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

CHIEF MEDICAL EXAMINER

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

Frank J. Broschart, M.D.

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

3/14/61

22a. BURIAL, CREMATION,
REMOVAL (Specify)
BURIAL

22b. DATE THEREOF
3/16/61

22c. NAME OF CEMETERY OR CREMATORIUM
ROCK CREEK CEMETERY

22d. LOCATION (City, town, or country)
WASHINGTON, D.C.

23. FUNERAL DIRECTOR

WALTER E. PUMPREY, INC.

Raymond L. Ziska

ADDRESS

SILVER SPRING, MD.

24a. REC'D BY REGISTRAR

MAR 20 '61

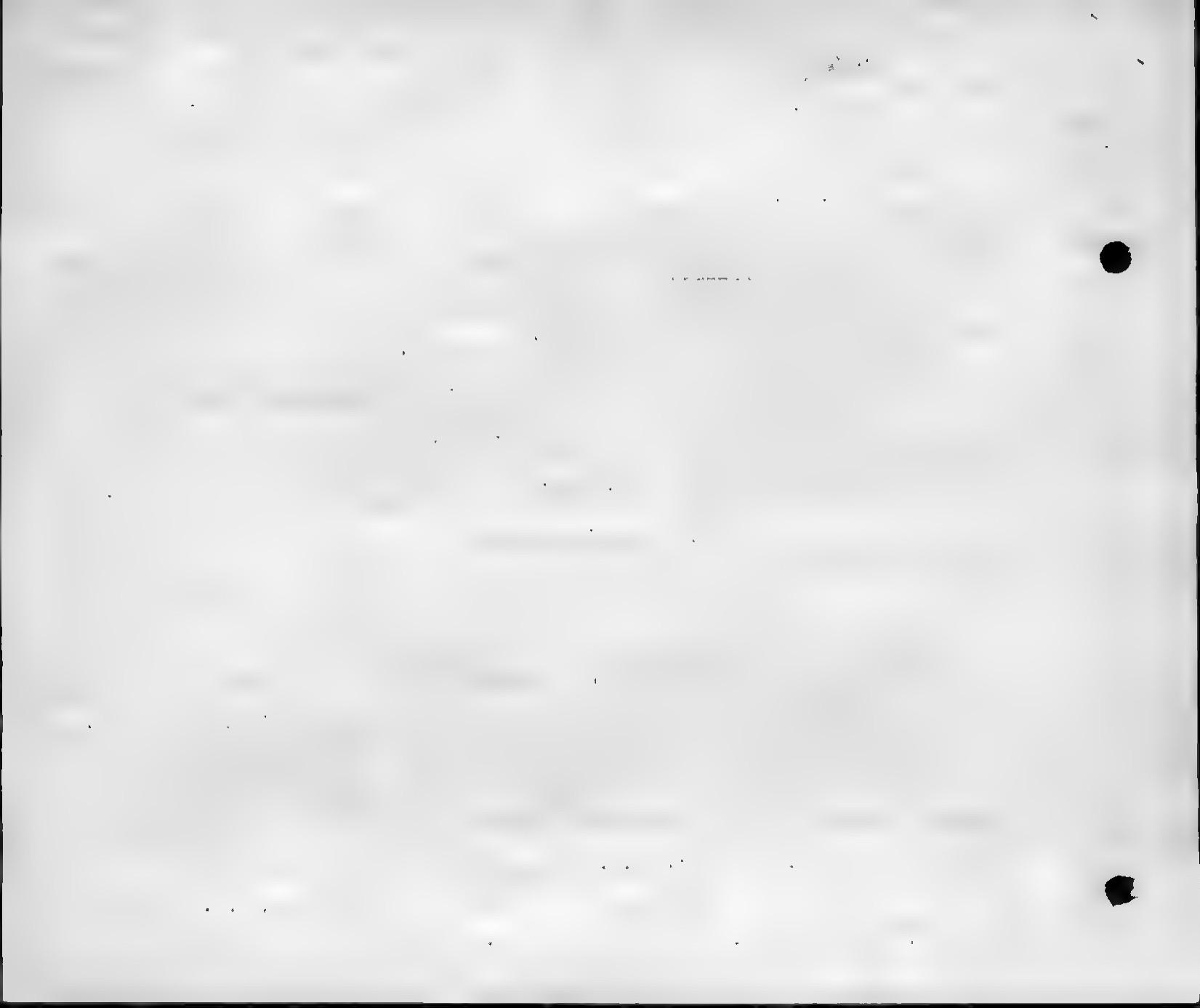
DATE

24b. REGISTRAR'S SIGNATURE

Carlton S. Kraus

TO REPORT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59



1
FOR STATE
HEALTH DEPT.

Item 10, 11, 12, 13 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3300 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13288

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington San. & Hospital

3. NAME OF
DECEASED
(Type or print)

First: Patricia Middle:

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

b. STATE

Maryland

b. COUNTY

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Adelphi

167-3-2

d. STREET ADDRESS

10406 Truxton Road

4. IS RESIDENCE
ON A FARM?

YES NO

Year

5. SEX

6. COLOR OR RACE

Female

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Student

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

3-21-41

Month Day Year

Month Day Year

Hours Min.

9. AGE (In years)
last birthday

19 yrs.

10. IF UNDER 1 YEAR

Months Days

Hours Min.

March 12

1961

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Kline

14. MOTHER'S MAIDEN NAME

Hazel V. Nelson

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give rank or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

220-38-1517 Hospital Admitting Record

INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

970.3

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Aspirin poisoning

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20c. TIME OF INJURY Month, Day, Year:
Hour a.m.

2:30 PM 3-12 1961

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

Reported to have taken 100-5 gr Aspirin tab.

20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

While at work Not While at work

factory, street, office bldg., etc.)

home Adelphia P.G. md

19. WAS AUTOPSY
PERFORMED?

YES NO

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

3-12-61

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORI

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

(State)

W. W. CHAMBERS CO.

RIVERDALE, MD.

ADDRESS

MAR 15 '61

DATUM

Arthur S. Krause



1
FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, write the word "Pending" in pencil in Item 18. Give Pages 1, 2 and 3 to Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

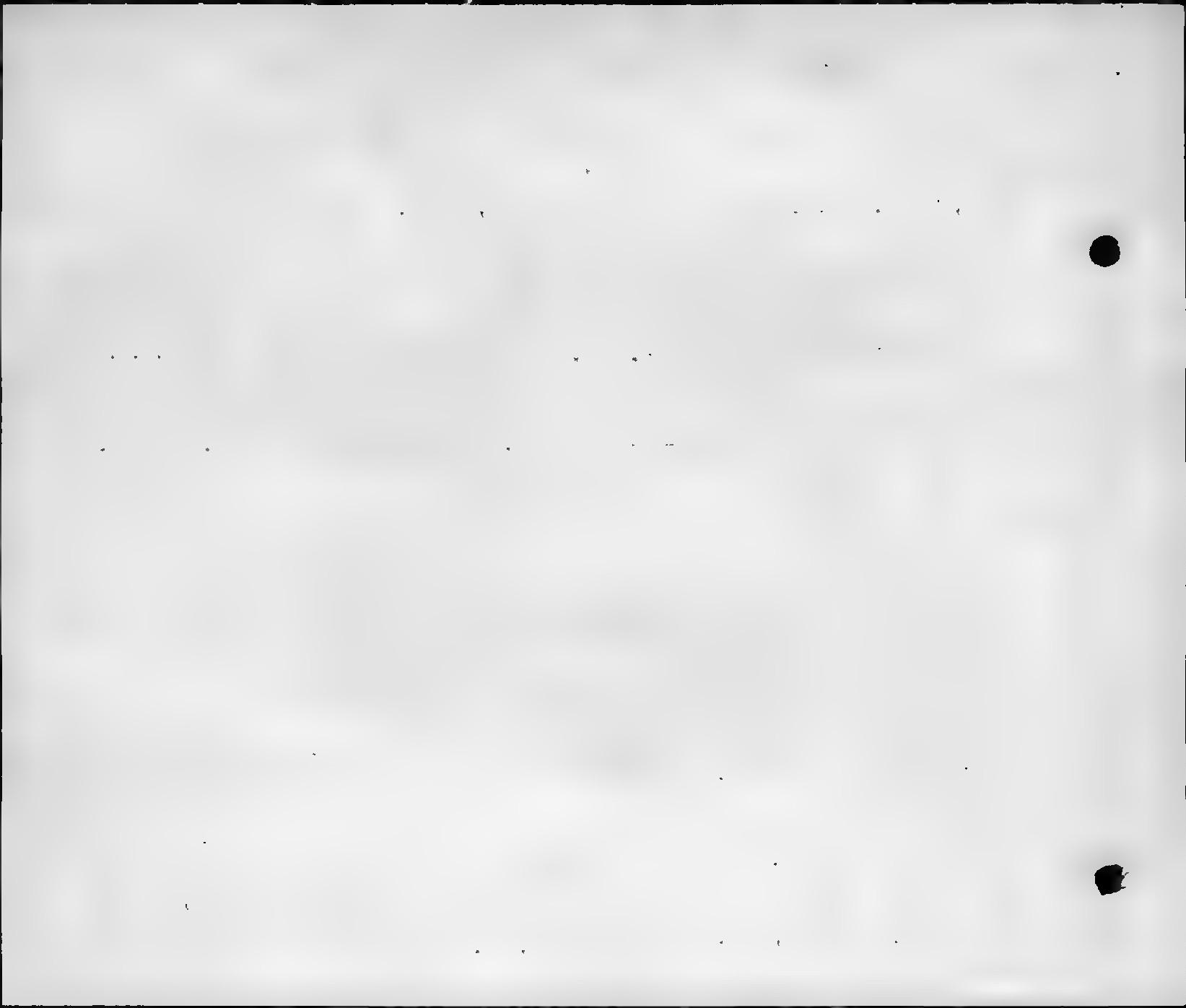
VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3301 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03283

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. LENGTH OF STAY IN lb 5 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 10,723 St. Paul Street		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) KENSINGTON	
f. STREET ADDRESS 10,723 ST. PAUL STREET		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDGAR		4. DATE OF DEATH Last Month Day Year MARCH 6 1961	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/1/94	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mathematician		10b. KIND OF BUSINESS OR INDUSTRY Naval Ord. Lab.	
11. BIRTHPLACE (State or foreign country) Lais, Estonia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME August Krahn		14. MOTHER'S MAIDEN NAME Helene Freund	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT 218-34-5461 Mrs. Dorothee Krahn 10723 St. Paul St. Address Kensington	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden Coronary occlusion	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
History of previous heart disease			
20c. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour e.m. p.m.		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) FRANK J. BROSCHEIT		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22e. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 3/9/61		22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM PARKLAWN CEMETERY	
23. FUNERAL DIRECTOR WANNER E. PUMPHREY, INC. Raymond A. Ziska		22d. LOCATION (City, town, or county) MONTGOMERY COUNTY, MARYLAND (State)	
ADDRESS SILVER SPRING, MD.		24e. REC'D BY REGISTRAR DATE MAR 10 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Krahn			



FOR STATE
HEALTH DEPT.

M

4 hours -
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death X

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3302 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

113294

1. PLACE OF DEATH
a. COUNTY

Montgomery
Silver Spring

MARYLAND

c. LENGTH OF STAY IN lb

1/2 hr.

b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town)

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

11105 Bucknell Dr

First Middle Last

3. NAME OF
DECEASED
(Type or print)

4. SEX

16. COLOR OR RACE

17. MARRIED NEVER MARRIED

WIDOWED DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or details of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Yes W W 11 213 34 3509 Mrs Tillie Krotz Hyattsville Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

if 20 DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying

cause last. (b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDIT ON GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

20e. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m. While Not Who a

p.m. at work at work

20d. INJURY OCCURRED While Not Who a

at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion

death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

CHIEF MEDICAL EXAMINER

ACTUAL SIGNATURE Frank J. Broschart M.D. ASSISTANT MEDICAL EXAMINER

NAME (Type) FRANK J. Broschart DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial March 22, 1961 Arlington National Cemetery

22b. DATE THEREOF MAR 22 '61

22c. NAME OF CEMETERY OR BURIAL GROUND

Arlington Virginia

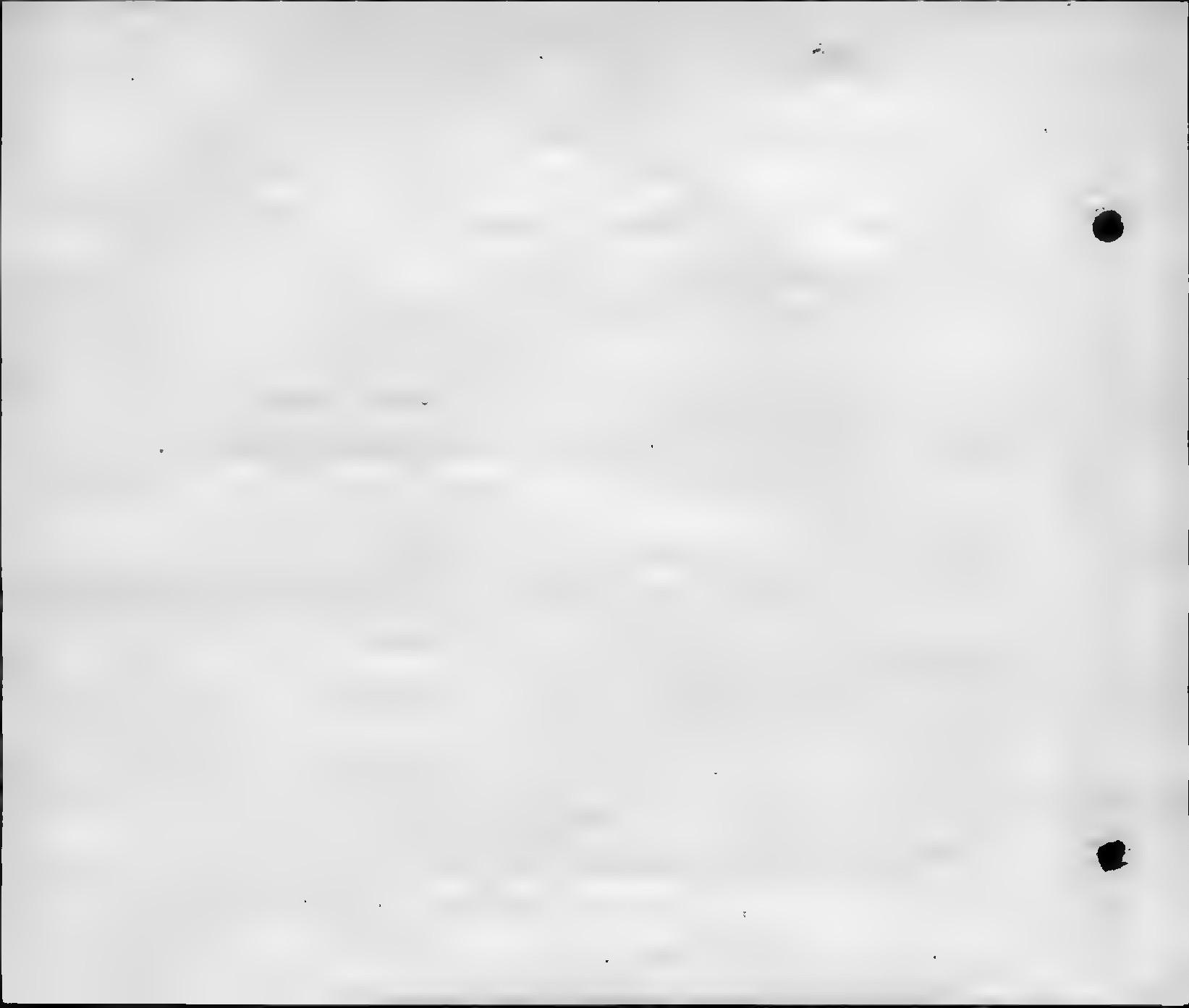
22d. LOCATION (City, town, or country) (State)

23. FUNERAL DIRECTOR ADDRESS

F. Gasch's Sons Hyattsville, Md.

24a. REC'D BY REG STRAR MAR 22 '61

24b. REGISTRAR'S SIGNATURE Arthur S. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

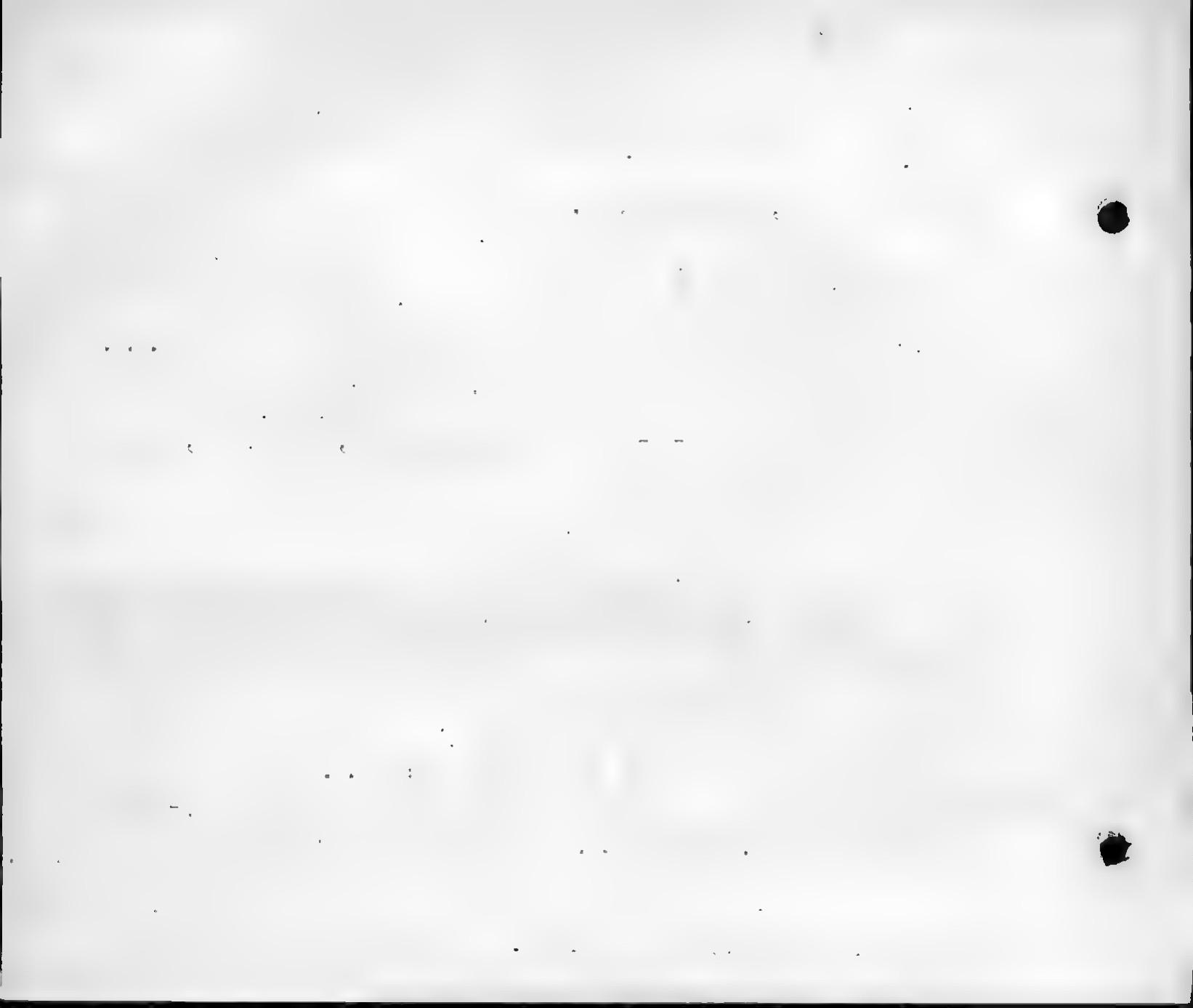
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 2c & c4, Form G-62 3/21/61.cac. 0329

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Pennsylvania	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 23 Days		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alverda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. STREET ADDRESS Box #6		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anthony		First	Middle Robert	Last Landi	4. DATE OF DEATH March 8, 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH February 26, 1912	9. AGE (In years last birthday) 49 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Factory		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Victor Landi		14. MOTHER'S MAIDEN NAME Theresa Pagni		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 194-01-6281		17. INFORMANT The Medical Records Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH			
Cardiac Arrest					
410X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)		Years			
DUE TO Rheumatic Heart Disease with (b)					
DUE TO Mitral Insufficiency (c)		Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from February 13 1961, to March 8, 1961 that (we) last saw the deceased alive on March 8, 1961, and that death occurred 10:25A.M. from the causes and on the date stated above.		22b. DATE SIGNED 3-9-61			
22a. SIGNATURE R. WILCOX, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) BENSON R. WILCOX, M.D.		22d. ADDRESS The Clinical Center National Institutes of Health, Bethesda, Md.			
23a. BURIAL/CREMATION REMOVAL (Specify) Burial-transit 3-9-61		23b. DATE THEREOF 3-9-61		23c. NAME OF CEMETERY OR CREMATORIAL Oakland Cemetery	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, Bethesda, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE MAR 14 '61	
				25b. REGISTRAR'S SIGNATURE Clifford L. Turner	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO MEDICAL DIRECTOR: After this certificate has been signed by the attending physician and countersigned by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3304

03292

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		b. COUNTY	
c. LENGTH OF STAY IN lb 119 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 1763 Columbia Rd., N.W. - Apt. 51	
e. FIRST NAME Florence		f. MIDDLE NAME LANE	
g. LAST NAME O'Toole		h. DATE OF DEATH March 15, 1961	
i. NAME OF DECEASED (Type or print) Female		j. DATE OF BIRTH 12-22-93	
k. SEX Caucasian		l. AGE (In years IF UNDER 1 YEAR last birthday) Months Days Hours Min. 67 yrs. 0 months 0 days 0 hours 0 min.	
m. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		n. KIND OF BUSINESS OR INDUSTRY own home	
o. BIRTHPLACE (County & State, or foreign country) Massachusetts		p. CITIZEN OF WHAT COUNTRY USA	
q. FATHER'S NAME Thomas E. O'Toole		r. MOTHER'S MAIDEN NAME Ellen Brown	
s. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service) No		t. SOCIAL SECURITY NO. u. INFORMANT none (S) R. I. Lane, 1710 Glenkarney Pl., SS, Md.	
v. ADDRESS		w. INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
x. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) ADENOCARCINOMA, COLON			
y. PART I. DEATH WAS CAUSED BY: IMMED ATC CAUSE (a) 152, 8 Conditions, if any, which gave rise to immediate cause (b) (c)		z. DUE TO ARTERIOSCLEROTIC HEART DISEASE	
aa. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC HEART DISEASE		bb. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
cc. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		dd. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
ee. TIME OF INJURY Hour a.m. p.m. 19		ff. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
gg. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		hh. (City or town) (County) (State)	
ii. I certify that (I) (this hospital) attended the deceased from Nov. 16, 1960 to March 15, 1961 , that (we) last saw the deceased alive on March 15, 1961 , and that death occurred at 8:10 PM M, from the causes and on the date stated above.		jj. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> kk. ADDRESS	
ll. SIGNATURE J. J. RYSKAMP, JR., LT, MC, USN		mm. DATE SIGNED 3-16-61	
nn. PHYSICIAN'S NAME (Type) Raymond L. Ziska		oo. LOCATION (City, town or county) Arlington (State) Virginia	
pp. BURIAL, CREMATION, REMOVAL (Specify) Burial		qq. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington National	
rr. FUNERAL DIRECTOR'S SIGNATURE Raymond L. Ziska		ss. REC'D. BY REGISTRAR MAR 21 1961 tt. REGISTRAR'S SIGNATURE Arthur L. Krause	
uu. VR A15 (4) 15M 9/60		vv. DATE	



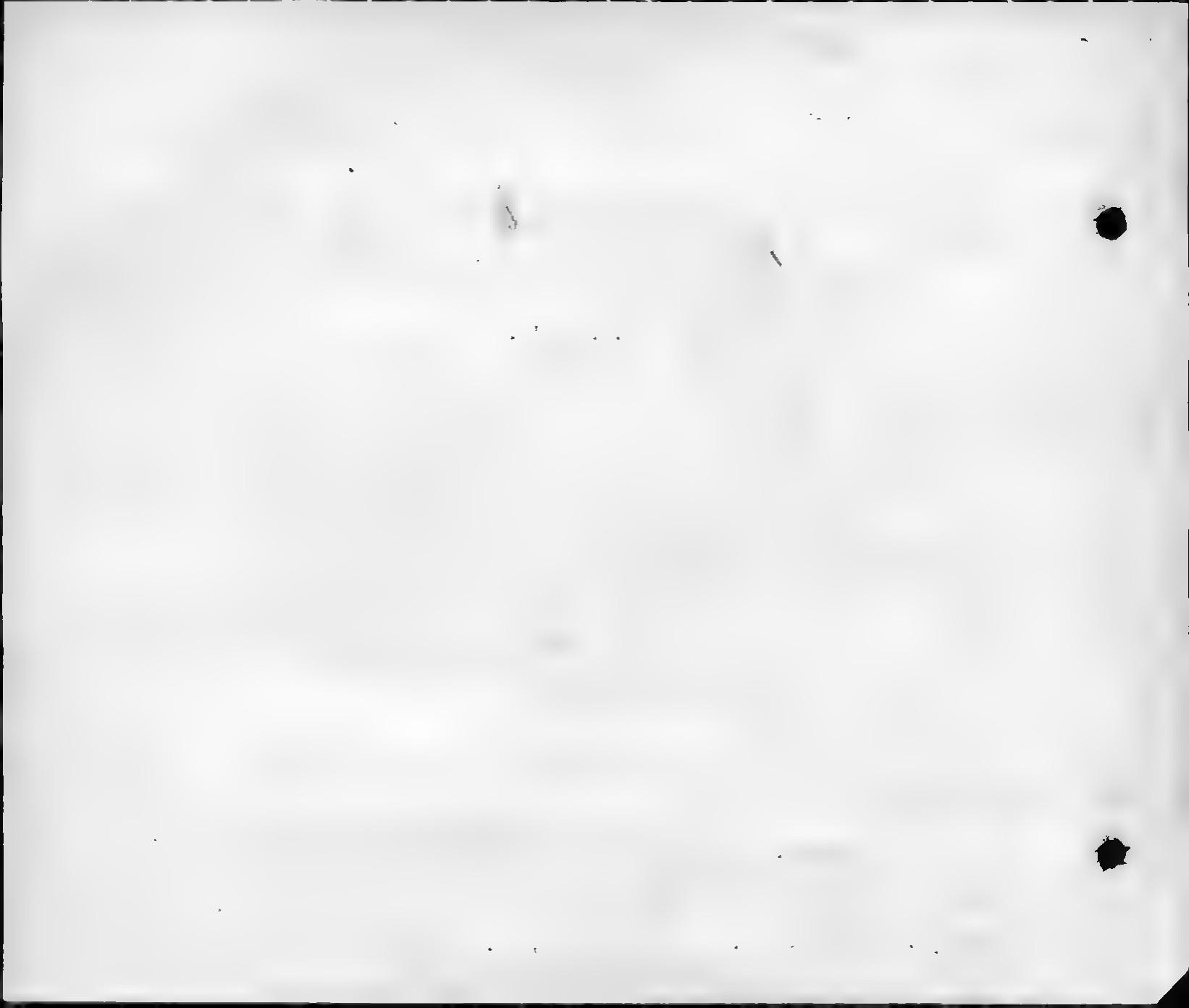
10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

11 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

0329-3
3305

1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If instit. or Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>MONTGOMERY</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>15 hours</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		d. STREET ADDRESS <i>7402 Wildwood Dr</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium and Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Philip</i>		Middle <i>Jett</i>		4. DATE OF DEATH <i>3</i>		Month <i>16</i>	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>25</i>	
				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <i>53 yrs</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Postal Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>C.O.C. U.S. GOVT.</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>Amer.</i>	
13. FATHER'S NAME <i>Samuel Rutherford</i>				14. MOTHER'S MAIDEN NAME <i>Edith</i>		LOCHER <i>Hospital Records</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>XXXXXX</i>		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarction & Rupture.</i> DUE TO <i>and palpitation</i> INTERVAL BETWEEN ONSET AND DEATH <i>18 hrs</i> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Occlusion</i> DUE TO <i>15 hrs -</i> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July 1956</i> to <i>March 16, 1961</i> , that (I) (we) last saw the deceased alive on <i>March 15, 1961</i> , and that death occurred on <i>5 PM</i> , from the causes and on the date stated above							
22a. SIGNATURE <i>James M. Whitlock</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <i>3-16-61</i>			
22c. PHYSICIAN'S NAME (Type) <i>JAMES M. WHITLOCK</i>		22d. ADDRESS <i>7717 Carroll Ave Takoma Park Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>3/10/61</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Ebenezer Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Loudon County, Virginia</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>WALTER E. PUMPHREY, INC.</i>		ADDRESS <i>SILVER SPRING, MD.</i>		25a. REC'D. BY REGISTRAR <i>MAR 21 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Charles S. Hause</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14
M
I
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3306

CERTIFICATE OF DEATH

13296

1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

TAKOMA PARK

c. LENGTH OF STAY IN lb

2hrs 45min

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington San. and Hospital

3. NAME OF
DECEASED
(Type or print)

First GERALD

Middle

4. SEX

Male

white

WIDOWED

DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

Theatre Owner

13. FATHER'S NAME

LOUIS LEHMANN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.

(Yes, no, or unknown) (If yes give rank or dates of service)

17. INFORMANT

Lena Lehman

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420 Myocardial Failure

Conditions, if any, which

give rise to immediate cause
(a), stating the underlying
cause last.

DE TO

(b) Myocardial infarction

DE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Arterio sclerotic CARDIO VASCULAR disease

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____
p.m. _____

20d. INJURY OCCURRED
Who Not White
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
(County) _____

(State) _____

21. I certify that (I) (this medical) attended the deceased from March 18, 1961, to March 25, 1961, that (I) (we) last saw the deceased alive on March 25, 1961, and that death occurred at _____, from the causes and on the date stated above.

22a. SIGNATURE

Paul Eanet

22c. PHYSICIAN'S
NAME (Type)

PAUL EANET

ATTENDING
M.D.

MED.
DIRECTOR

STAFF
PHYS.

3-25-61
22b. DATE
SIGNED

23a. BY AIR, CREMATION, REMOVAL (Specify)

Buried

23b. DATE THEREOF

3-25-61

23c. NAME OF CEMETERY OR CREMATORIAL

Canton Miss

23d. LOCATION (City, town or county)

Canton Miss

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

Arthur S. Kraus

ADDRESS

4812 Gaithersburg

MD 20878

25a. REC'D BY REGISTRAR

MAR 27 '61

DATE

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



1
FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted within 24 hours after death. If any delay is necessary, please rule the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M.3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03295

1. PLACE OF DEATH

3307

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, wr to RURAL and give nearest town)

Rockville

c. LENGTH OF STAY IN MD

4 hrs

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

P.E.P. Co. Generation Station

3. NAME OF
(Type or print)

Frank Andrew Lesko

Last

4. DATE
OF
DEATH

Month

Day

Year

March 10

1961

5. SEX

6. COLOR OR RACE

male white

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Plummer Construction

13. FATHER'S NAME

Andrew Jefco - 517-10-1641

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank date of service)

no

16. SOCIAL SECURITY NO. 17. INFORMANT

Robertson Brown

9. AGE (In years last birthday) IF UNDER 1 YEAR

Months Days Hours Min.

42 yrs.

12. CITIZEN OF WHAT COUNTRY?

U.S.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

420

Conditions, if any, which gave rise to immediate cause
(a), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

CORONARY OCCLUSION

INTERVAL BETWEEN
ONSET AND DEATH

sudden

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20c. TIME OF INJURY Month Day, Year
Hour a.m. 19
p.m.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)
(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from Natural causes , Accident , Suicide , Homicide , Undetermined manner

CHIEF MEDICAL EXAMINER

ACTUAL
SIGNATURE

Frank J. Bloschert

ASSISTANT MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S
NAME (Type)

FRANK J. Bloschert

DEPUTY MEDICAL EXAMINER

3-10-61

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

Burial March 15, 1961 Arlington National

22d. LOCATION (City, town, or country)

(State)

Arlington Virginia

23. FUNERAL DIRECTOR

ADDRESS

F. Gasch's Sons Hyattsville, Md.

24a. REC'D BY REGISTRAR

DATE MAR 16 '61

24b. REGISTRAR'S SIGNATURE

Arthur L. Krause



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending Physician and completely filled in, it may be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3308

CERTIFICATE OF DEATH

11324P

1. PLACE OF DEATH a. COUNTY MONTG.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE D.C.		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRLAND		c LENGTH OF STAY IN 1b 1 mos.		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAIRLAND NURSING HOME				d STREET ADDRESS 3500 - O ST. N.W.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print)	First BELLA	Middle —	Last LEVIN	4. DATE OF DEATH MARCH 21 - 1961	Month March	Day 21	Year 1961
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH JULY-1-1893	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO 98-48-5456		17. INFORMANT SAMUEL LEVIN 3500-O-Nce		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis						INTERVAL BETWEEN ONSET AND DEATH 10 weeks	
32X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis						4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Rheumatic Heart Disease, mitral stenosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)					
20c. TIME OF INJURY Month Day Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ 1952 to 1961, that (I) (we) last saw the deceased alive on 3/21 1961, and that death occurred at 9 AM, from the causes and on the date stated above							
22a. SIGNATURE Irving W. Winik		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED 3/21/61	
22c. PHYSICIAN'S NAME (Type) Irving W. Winik		22d. ADDRESS 3900 McKinley St. N.W.					
23a. BURIAL, CREMATION, REMOVAL (Specify) General		23b. DATE THEREOF 3/23/61		23c. NAME OF CEMETERY OR CREMATORIUM Geo. Wash. Cem.		23d. LOCATION (City, town, or county) Bethesda, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Irving Winik Home		ADDRESS 4217-9 St Lee.		25a. REC'D BY REGISTRAR DATE MAR 23 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3309

CERTIFICATE OF DEATH

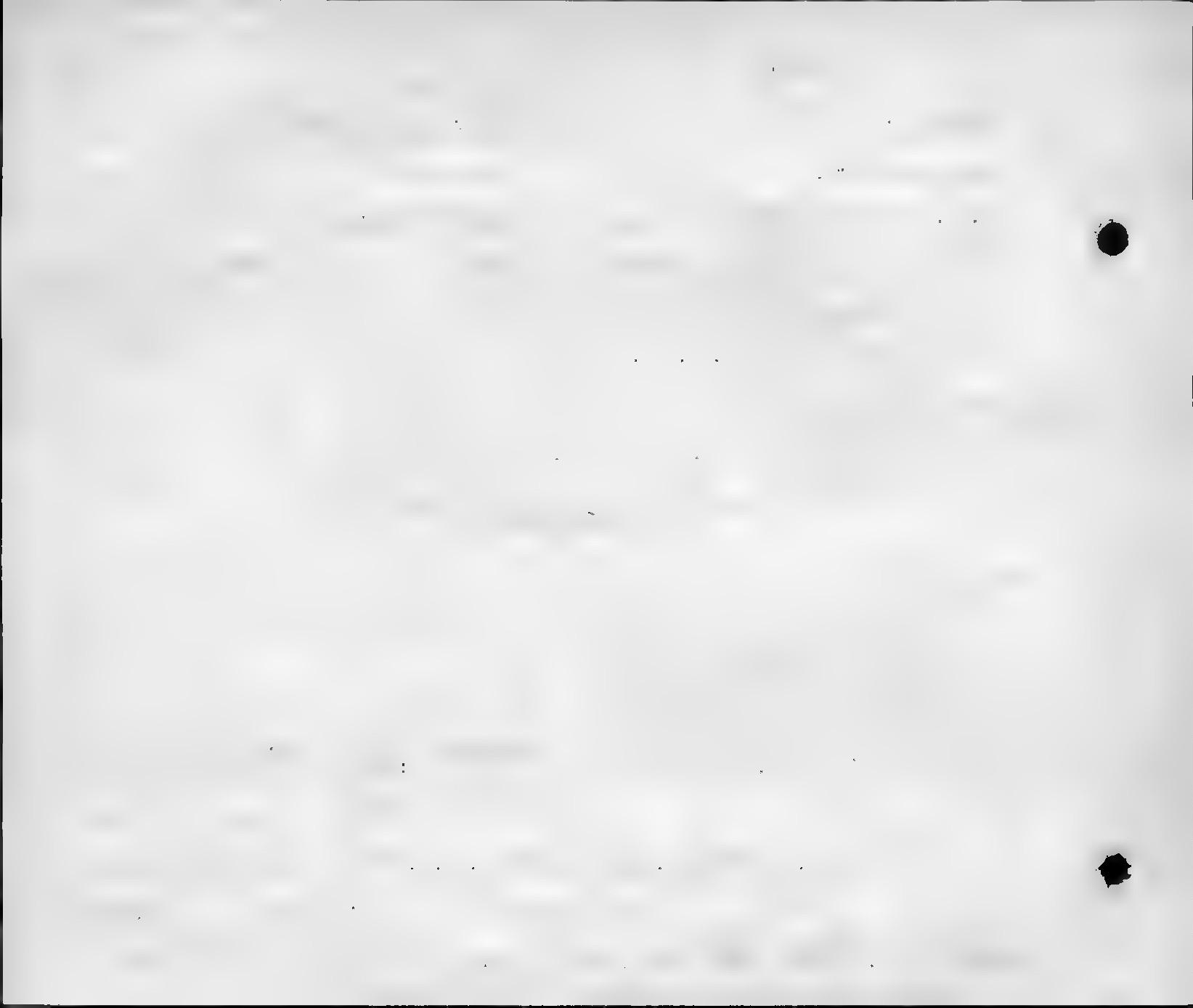
103297

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH a. COUNTY Montgomery	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE District of Columbia b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)	c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital				
3. NAME OF DECEASED (Type or print) John Mathew LIESCH	First Middle Last			
4. DATE OF DEATH March 20 1961	Month Day Year			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-17-87	9. AGE (in years less birthday) 73 Months 0 Days 0 IF UNDER 1 YEAR Hours 0 Min. 0 IF UNDER 24 HRS.
10a. USAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Service		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.		11. BIRTHPLACE (County & State or foreign country) Washington, D. C.
13. FATHER'S NAME Jacob LIESCH		14. MOTHER'S MAIDEN NAME Emilia BRASOLE		12. CITIZEN OF WHAT COUNTRY USA
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWI		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Hospital Records
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)		adenocarcinoma, liver, with metastasis INTERVAL BETWEEN ONSET AND DEATH 7-3 mos		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO 156.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCR BE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Hour e.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 15 1961 to March 20, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 20 1961 , and that death occurred at 6:50 AM from the causes and on the date stated above.				
22a. SIGNATURE <i>Paul G. Lineweaver</i>		22b. DATE SIGNED 3-20-61		
22c. PHYSICIAN'S NAME (Type) Paul G. LINWEAVER, LT, MC, USN	ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-23-61	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Arlington National WashDC		23d. LOCATION (City, town or county) Arlington (State) Virginia
24. FUNERAL DIRECTOR'S SIGNATURE <i>Summons Bros. Funeral Home</i>		25a. REC'D. BY REGISTRAR MAR 23 '61 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		
15M 9/60		DATE		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3310

103298

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH

a. COUNTY

Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park,

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington Sanitarium and Hospital

3. NAME OF DECEASED
(Type or print)

5. SEX

Male

10a. U.S. OCCUPATION (Give kind of work done during most of working life, even if retired)

Supervisor

13. FATHER'S NAME

Willis Longley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

No

18. CRUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c))

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

4120

DUE TO
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.(b) DUE TO
Chronic Coronary Insufficiency

(c) DUE TO

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

Hour e.m.

p.m.

19

at work

at work

at work

22c. PHYSICIAN'S NAME (Type)

23a. BURIAL, CREMATION REMOVAL (Specify)

BURIAL

3/8/61

24. FUNERAL DIRECTOR'S SIGNATURE

WALTER E. PUMPHREY, INC.

Raymond A. Ziskin

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

d. STREET ADDRESS

312 Southwest Drive

e. LENGTH OF STAY IN 1b

DOA

Last

Month

Day

Year

5

1961

f. 15. RESIDENCE ON A FARM?

YES NO

9. AGE (In years last birthday)

54 yrs

10. IF UNDER 1 YEAR

Months

Days

11. IF UNDER 24 HRS.

Hours

Min.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

16. SOCIAL SECURITY NO

577-01-9148

17. INFORMANT

Mrs. Adrienne J. Longley, 312 Southwest Dr., Silver Spring, Md.

Address

INTERVAL BETWEEN
ONSET AND DEATH
30-40 min

5-6 yrs.

19. WAS AUTOPSY PERFORMED?

YES NO

21. I certify that (I) (this hospital) attended the deceased from April, 1961, to May, 1961, that (I) (we) last saw the deceased alive on Feb. 20, 1961, and that death occurred at 11 p.m. from the causes and on the date stated above

22e. SIGNATURE

M.D. ATTENDING PHYS. ✓ MED. DIRECTOR STAFF PHYS.

22d. ADDRESS

7112 Willow Ave

TAKOMA PARK, Md.

3/6/61

23c. NAME OF CEMETERY OR CREMATORIUM

Darnestown Presbyterian Church Cemetery

23d. LOCATION (City, town or county) (State)

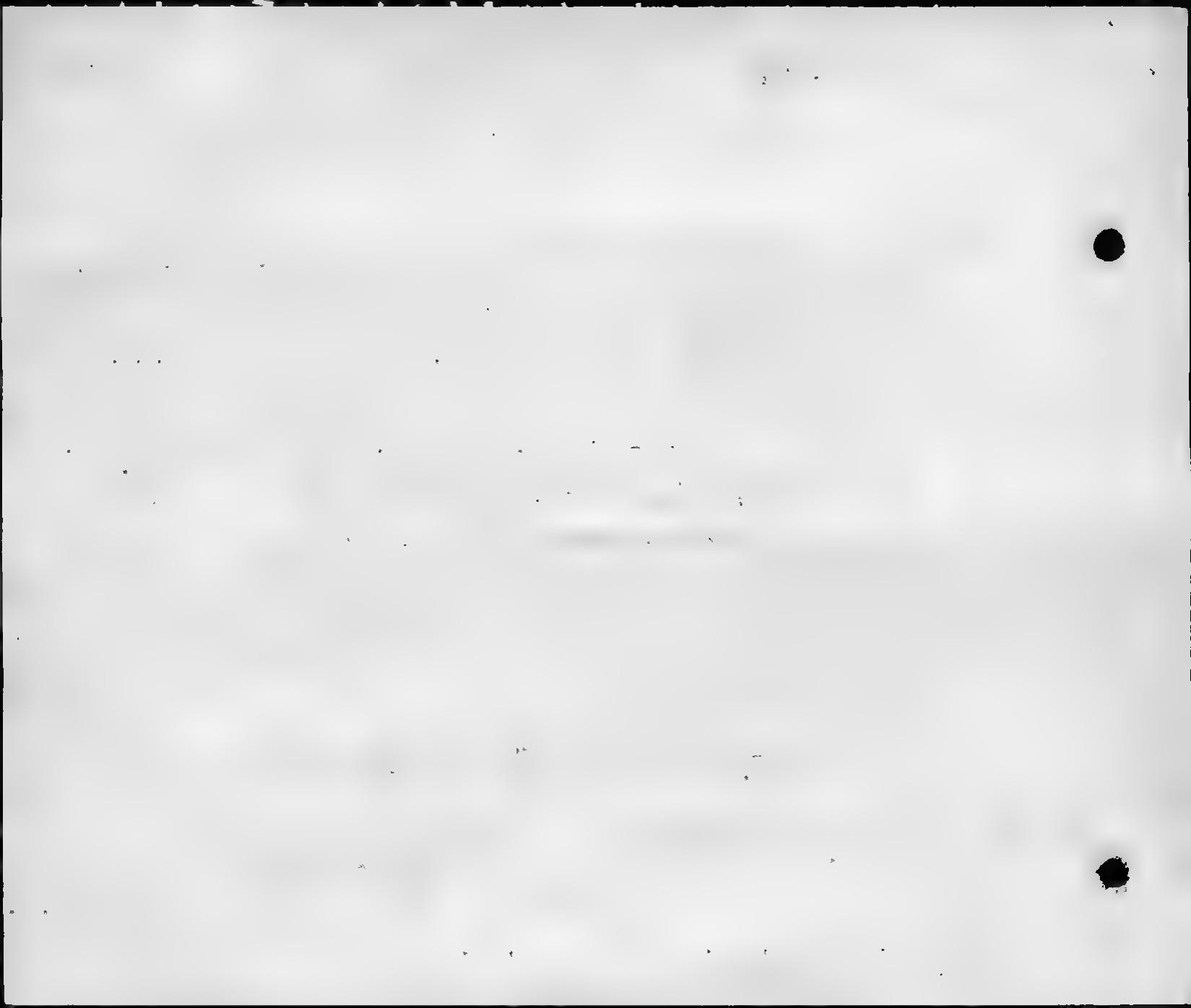
Darnestown Montgomery Co., Md.

25e. REC'D BY REGISTRAR

DATE MAR 9 '61

25b. REGISTRAR'S SIGNATURE

John S. Smith



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3311

03299

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FEDERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy, pages 1 & 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY

Montgomery

b. CITY OR TOWN, if outside corporate limits, write RURAL and give nearest town

Bethesda (Rural)

d. NAME OF HOSPITAL OR INSTITUTION, if not in hospital, give street address

U. S. Naval Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

William

Jones

5. SEX

6. COLOR OR RACE

Male

Caucasian

10a. US LAB. OCCUPATION (Give kind of work done during most of working life, even if retired)

Officer

W DOWED DIVORCED

13. FATHER'S NAME

Harry MARSH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service)

Yes

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY
(IMMEDIATE CAUSE) (a)DUE TO
{ Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last. } (b)DUE TO
{ (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I, (a)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year

Hour a.m. _____

p.m. _____

19

Wh. at work Not Wh. at work at work at work

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm,

factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (this hospital) attended the deceased from Aug. 15, 1960, to March 23, 1961, that (we) last

saw the deceased alive on March 23, 1961, and that death occurred at 3 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Larry J. Hines

22b. DATE SIGNED

3-24-61

22c. PHYSICIAN'S
NAME (Type)

Larry J. HINES, CDR, MC, USN

23a. BURIAL, CREMATION
REMOVAL (Specify)

Cremation

3-25-61

23b. DATE THEREOF

Ft. Lincoln Crematory

ADDRESS

W.W. Chambers Co., 1400 Chapin St., NW, WashDC

23c. NAME OF CEMETERY OR CREMATORI

23d. LOCATION (City, town or county)

(State)

Washington, D. C.

24. FUNERAL DIRECTOR'S SIGNATURE

Arthur S. Krause

ADDRESS

DATE MAR 28 '61

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Arthur S. Krause

8

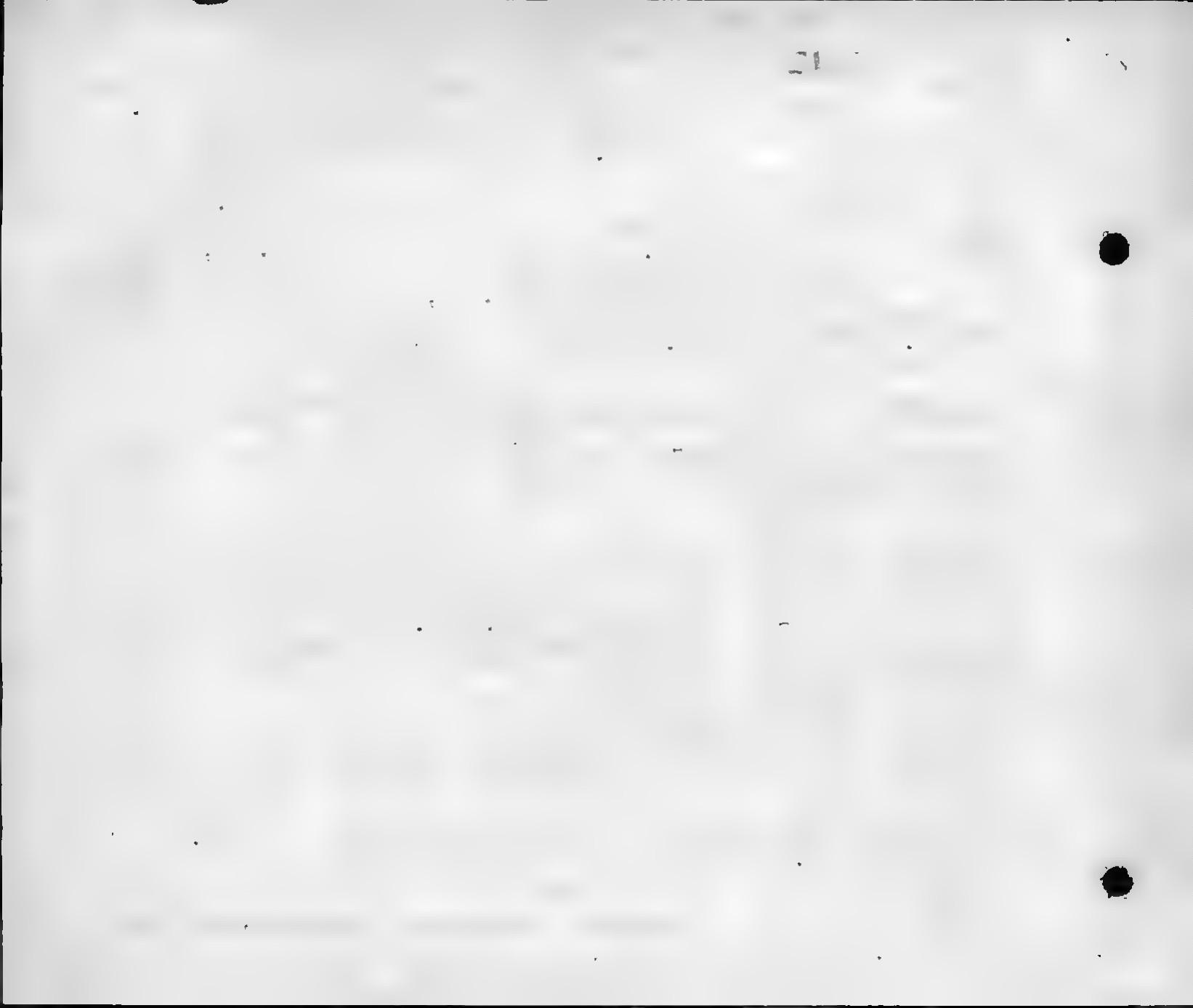
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3312 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **03360**

TO REPUTY MEDICAL EXAMINER: This certificate should be submitted within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the remains prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 4 mo.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Resnor Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
f. STREET ADDRESS 4750 Chevy Chase Dr.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Charles	Middle E.	Last Mason
4. DATE OF DEATH	Month Mar.	Day 26, 1961	Year 19
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1900
9. AGE (In years, months/birthday) 60 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0	12. IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done) US Govt.	10b. KIND OF BUSINESS OR INDUSTRY Pub. Relations	11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. Yes - Unknown	17. INFORMANT Nursing Home Record	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion			
DUE TO 420.1			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension - C V A several mos. ago.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Frank J. Broschart	DATE SIGNED Mar. 26, 1961		
22a. BURIAL, CREMATON, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/28/61	22c. NAME OF CEMETERY OR CREMATORIUM Parklawn Cemetery	22d. LOCATION (City, town, or county) Rockville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland	ADDRESS	24a. REC'D BY REGISTRAR DATE MAR 28 '61	24b. REGISTRAR'S SIGNATURE <i>Clinton S. French</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

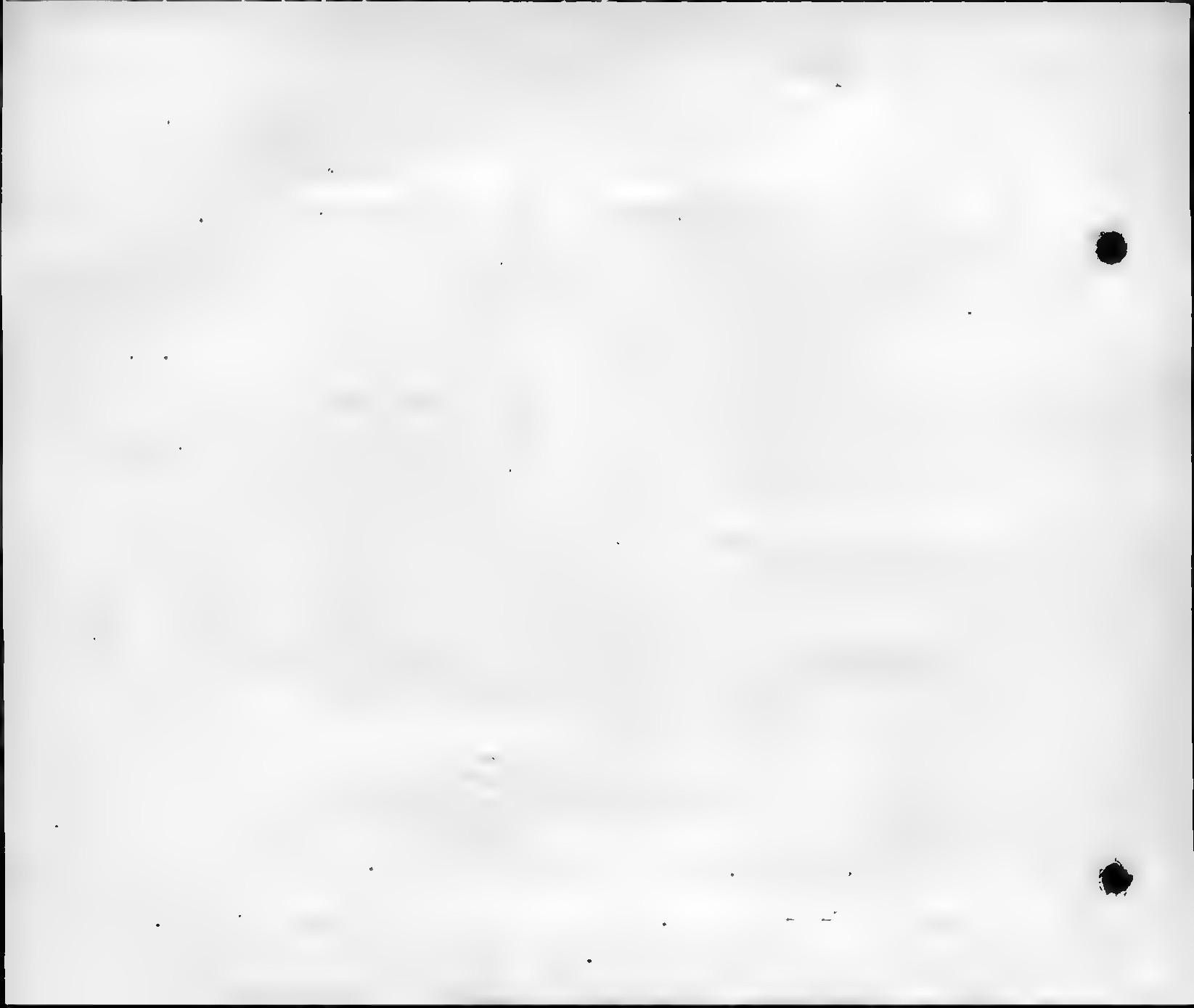
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3313

03301

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 13 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG		d. STREET ADDRESS 3 SOUTH FREDERICK AVE.					
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First BILLY	Middle BEN	Last McFARLAND, JR.	4. DATE OF DEATH MARCH 26 19 61	Month MARCH	Day 26	Year 19 61			
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 3/26/61	9. AGE (In years last birthday) yrs. 13	IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
8. MARITAL STATUS WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME BILLY BEN McFARLAND				14. MOTHER'S MAIDEN NAME RACHEL FRANCES COLEMAN							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 762.5		16. SOCIAL SECURITY NO.		17. INFORMANT		HOSPITAL RECORDS, OLNEY, MARYLAND				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity and Instinctive Conditions, if any, which gave rise to immediate cause (a), slotting the under- lying cause last. Atelectasis of lungs.		DUE TO 762.5		(b) DUE TO		(c)				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Olney		(County) Maryland		(State)	
21. I certify that (I) (this hospital) attended the deceased from 3/26 1961 to 3/26 1961 , that (I) (we) last saw the deceased alive on 3/26 1961 , and that death occurred at Maryland , from the causes and on the date stated above.											
22a. SIGNATURE Richard A. Yates MD		M.D. <input type="checkbox"/> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED 3/27/61					
22c. PHYSICIAN'S NAME (Type) Richard A. Yates, M.D.		22d. ADDRESS Olney, Md.									
23a. BUR. A. CREMAT. ON REMOVAL (Specify) Burial		23b. DATE THEREOF 3-29-61		23c. NAME OF CEMETERY OR CREMATORIAL St. Paul		23d. LOCATION (City, town, or county) Laytonsville, Md.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		ADDRESS Laytonsville, Md.				25a. REC'D BY REGISTRAR DATE APR 3 '61		25b. REGISTRAR'S SIGNATURE L. W. S. Khan			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3314

03302

1. PLACE OF DEATH
a. COUNTY

Montgomery

b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town)

Rockville

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

16605 Old Frederick Rd.

MARYLAND

c. LENGTH OF STAY IN HS

2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)

e. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town)

Rockville

d. STREET ADDRESS

16605 Old Frederick Rd.

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED

July 20, 1882

9. AGE (in years
last birthday)

78

yrs

IF UNDER 1 YEAR
Months Days

7

18

IF UNDER 24 HRS
Hours Min.

18

18

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Retired

New Castle, Delaware

12. CITIZEN OF WHAT COUNTRY

U. S.

13. FATHER'S NAME

Harry H. McFarlin

14. MOTHER'S MAIDEN NAME

Mary R. Faulkner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

N

16. SOCIAL SECURITY NO

17. INFORMANT

188-16-8439

Mrs. Otho Butcher-Friend-same above

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

Gastric intestinal Removable | 2 weeks

DUE TO

Carcinoma of intestine | about 1 yr.

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

MEDICAL CERTIFICATION

19. WAS AUTOPSY
PERFORMED?
YES NO 20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Oct. 28, 1960 to March 7, 1961, that (I) (we) last saw the deceased alive on March 7, 1961, and that death occurred at 9 p.m. from the causes and on the date stated above.

22a. GENDER

M.D.

ATTENDING
PHYSMED
DIRECTORSTAFF
PHYSMarch 9, 1961
22b. DATE
SIGNED22c. PHYSICIAN'S
NAME (Type)

G. Bowditch Hunter, Jr., M.D. 809 Veirs Mill Rd., Rockville, Md.

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

3/11/1961

23c. NAME OF CEMETERY OR CREMATORY

St. George's Cemetery

23d. LOCATION (City, town or county)

St. George's Delaware

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

Robert A. Pumphrey Bethesda, Maryland

ADDRESS

25a. REGD BY REGISTRAR

MAR 13 1961

25b. REGISTRAR'S SIGNATURE

Curtis J. Hunt

DATE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

(03303)

3315

1. PLACE OF DEATH
a. COUNTY

MONT

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Ednor

MARYLAND

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

ELMONT NURSING HOME

3. NAME OF
DECESSED
(Type or print)

ALTA MCILWEE

First

Middle

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)

a. STATE

M.D.

b. COUNTY

MONT

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

DERWOOD

d. STREET ADDRESS

FD 2002, M.D.

e. IS RESIDENCE
ON A FARM?
YES NO

5. SEX

6. COLOR OR RACE

F

W

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSE-WIFER

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

2-5-38

Last

First

Month

Day

Year

3

5

1961

9. AGE (In years last birthday) IF UNDER 1 YEAR
73 yrs. Months Days Hours Min

13. FATHER'S NAME

1554C A. MCILWEE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT
(Yes, no, or unknown) (If yes, give year and date of service)

NO

none

11. BIRTHPLACE (County & State, or foreign country)

MUNSEY IND.

U.S.

14. MOTHER'S MAIDEN NAME

WILLIS

Address

Ednor M.D.

INTERVAL BETWEEN
ONSET AND DEATH

7 Days

4 MO.

4. DATE
OF
DEATH

10 years

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Bronchopneumonia - Bilateral

420.0
Conditions, if any, which
gave rise to Immediate cause
(e), stating the underlying
cause last.

b)
DUE TO
Chronic Heart Failure

(c)

Attherosclerotic Heart Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

(City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from JUNE 1960 to FEB 5 1961, that (I) (we) last saw the deceased alive on FEB 5 1961, and that death occurred at 11 AM, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

WILLIAM FRANK, M.D.

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22d. ADDRESS

544 W. MONTGOMERY AVE
ROCKVILLE M.D.

22b. DATE
SIGNED

23a. BURIAL, CREMATION, OR REMOVAL (Specify)

Burial

23b. DATE THEREOF
March 8, 1961

24. FUNERAL DIRECTOR'S SIGNATURE

Francis L. Barber Laytonsville, Md.

23c. NAME OF CEMETERY OR CREMATORIUM

ADDRESS

Star Tannery, Virginia

25a. REC'D BY REGISTRAR

MAR 8 '61

25b. REGISTRAR'S SIGNATURE

Charles S. Kline

15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3316

1. PLACE OF DEATH
a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

U. S. Naval Hospital

3. NAME OF DECEASED
(Type or print)

5. SEX

Female

13. FATHER'S NAME

Samuel Callaway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and dates of service)

No

16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

17. DUE TO
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)
DUE TO
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(c)

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Virginia

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Alexandria
d. STREET ADDRESS

IS RESIDENCE
ON A FARM?
YES NO

2409 Menckin Drive - Apt. 203

Levi 4. DATE OF DEATH March 2 1961

5. AGE (In years) IF UNDER 1 YEAR
Last birthday Months Days Hours Min.

9-15-99

6. BIRTHPLACE (Country & State, or foreign country)

11. CITIZEN OF WHAT COUNTRY?

USA

Alabama

14. MOTHER'S MAIDEN NAME

Mary L. Daniels

Address

(H) BGEN Wm. N. McKelvy, USMC, Ret., same as #2

INTERVAL BETWEEN
ONSET AND DEATH
6 yrs.

MEDICAL CERTIFICATION

20a. TIME OF INJURY Month, Day, Year

Hour a.m.
p.m.

19

20b. INJURY OCCURRED While Not While
at work at work

20c. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20d. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from July 8, 1960 to March 2, 1961, that (X) (we) last saw the deceased alive on March 2, 1961, and that death occurred at ... M, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

G. B. TOWNSEND, LT, MC, USN

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22d. ADDRESS

22b. DATE
SIGNED
3-2-61

23a. BURIAL, CREMATION, DATE THEREOF
REMOVAL (Specify)

Burial

3-6-61

23c. NAME OF CEMETERY OR CREMATORIAL

Arlington National

23d. LOCATION (City, town or county)

Arlington

(State)
Virginia

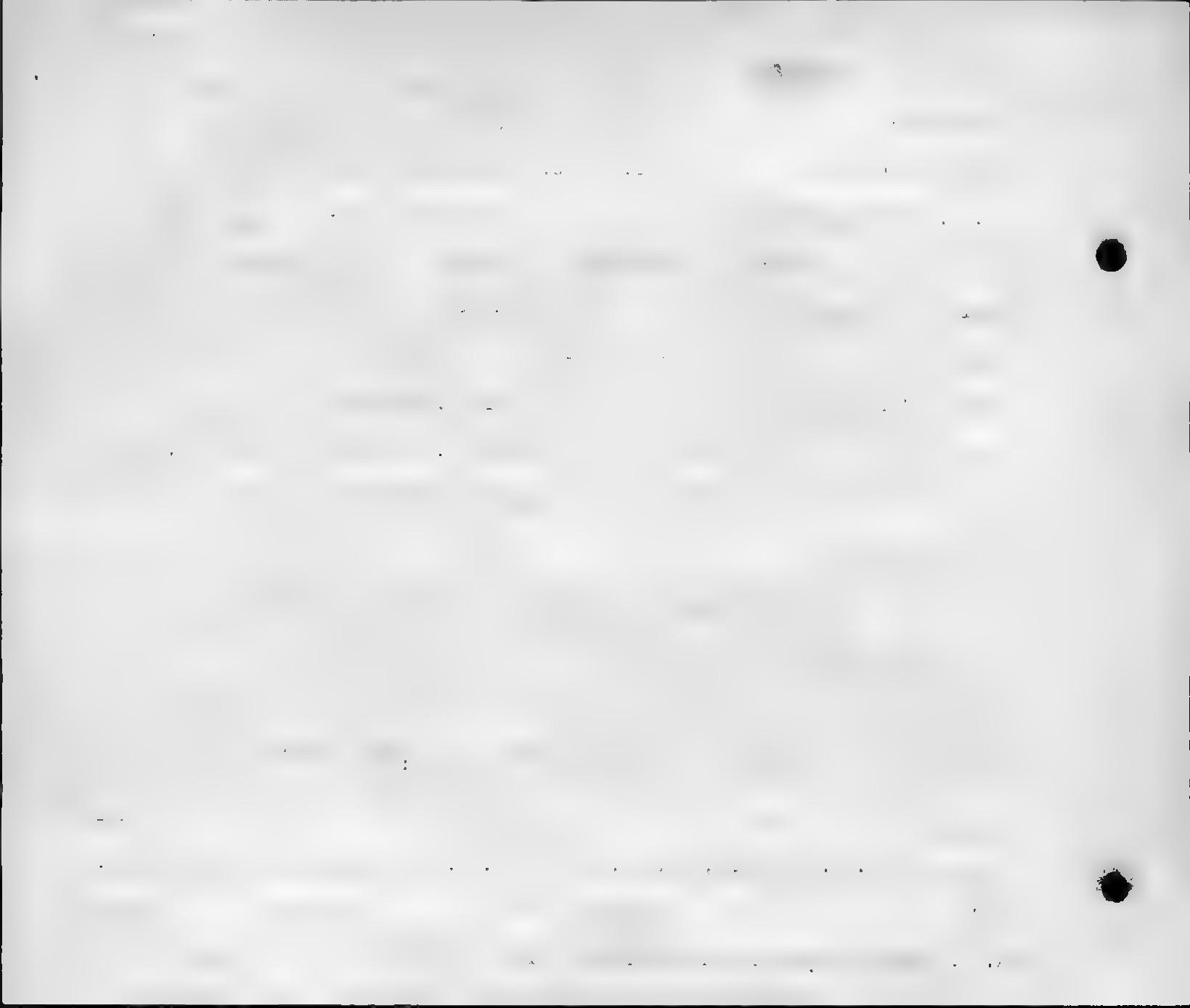
24. FUNERAL DIRECTOR'S SIGNATURE

R. A. Pumphrey Funeral Home, Bethesda, Md.

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

MAR 6 '61

Arthur S. Krause



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3317

CERTIFICATE OF DEATH

03305

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M
C

1. PLACE OF DEATH
a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

U. S. Naval Hospital

3. NAME OF
DECEASED
(Type or print)

Richardson

5. SEX

Male

6. COLOR OR RACE

Negro

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

13. FATHER'S NAME

Richardson MC KNIGHT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes, give rank or date of service]

No

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

754.5

Conditions, if any, which

gave rise to immediate cause

(a), stating the underlying

cause last.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

INTERVAL BETWEEN
ONSET AND DEATH

at birth

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

YES NO 20c. TIME OF INJURY Month, Day, Year Hour a.m. 20d. INJURY OCCURRED While at work Not While at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

p.m. 19

21. I certify that (this hospital) attended the deceased from March 10, 1961, to March 20, 1961, that (we) last saw the deceased alive on March 20, 1961, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE

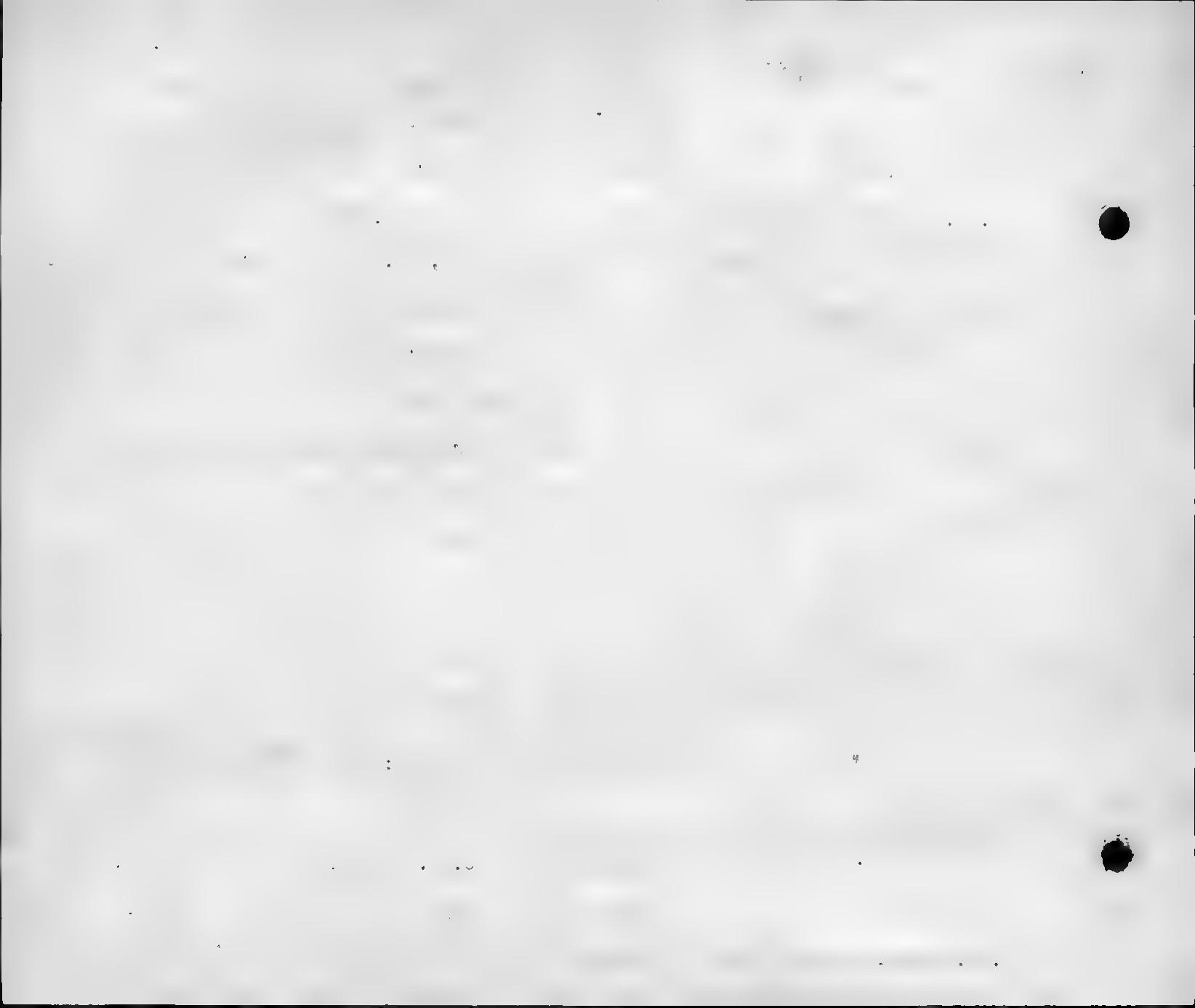
22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) C. W. BRAMLETT, LT, MC, USN M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. 3-21-61

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF Burial-Shipment-3-22-61 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Green Lawn Cemetery WashDC 23d. LOCATION (City, town or county) (State) Chester Pa.

24. FUNERAL DIRECTOR'S SIGNATURE B. F. Taylor Funeral Home, 909 6th St., NW, ADDRESS 25a. REC'D BY REGISTRAR Arthur S. House 25b. REGISTRAR'S SIGNATURE

DATE MAR 23 '61



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that this death certificate be executed within 24 hours after death. Page 4

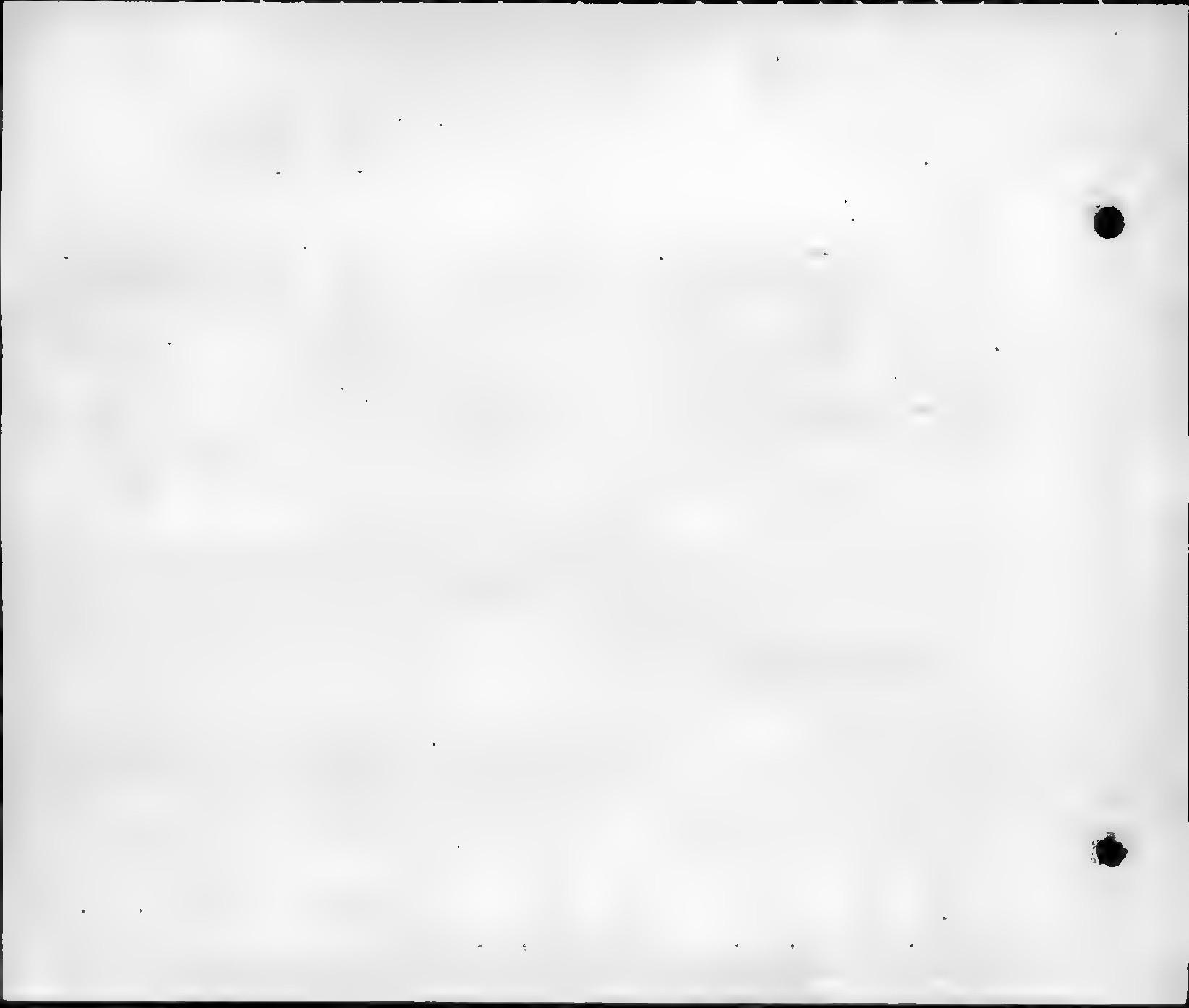
may be reported by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

09

I

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND												13306		
3318						CERTIFICATE OF DEATH								
1. PLACE OF DEATH			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)								
a. COUNTY			Montgomery			a. STATE			Maryland			b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Rural			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Silver Spring			Montgomery		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			Brooke Grove Foundation Inc.			d. STREET ADDRESS			9305 Flower Ave			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH			Month	Day	Year			
Mrs. Martha			Q.	M.	Sorley	March 31					1961			
5. SEX			6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday)			F. UNDER 1 YEAR	IF UNDER 24 HRS				
F			W	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	Feb. 8, 1877			84	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY						11. BIRTHPLACE (State or foreign country)		
Sales mgr. Dept. Store												Newry Ireland U.S.A.		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME								
Edward Quinn						Anna Daly						Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.						17. INFORMANT		
No						?						Dorothy Quinn Silver Spring		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]												INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cervix Thrombosis = occlusion = 420.1 DUE TO myometrial infarction												5 mos		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO } (c) Distant metastasis to abd														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County)		(State)			
Hour a.m. 19														
21. I certify that (I) (this hospital) attended the deceased from 12-20-19 to 31 March 1961, that (I) (we) last saw the deceased alive on 25 March 1961, and that death occurred at 11 A.M. from the causes and on the date stated above														
22a. SIGNATURE						M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
John B. Ziegler														
22c. PHYSICIAN'S NAME (Type)						ADDRESS			22d. ADDRESS					
John B. Ziegler						DC 157, MD.			DC 157, MD.					
23a. BUR. A. CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION (City, town, or county)			(State)		
TRANS. & BURIAL 4/1/61						FERNWOOD CEMETERY			FERNWOOD, DELAWARE CO., PA.					
24. FUNERAL DIRECTOR'S SIGNATURE			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
WARNER E. PUMPHREY, INC.			SILVER SPRING, MD.			DATA APR 4 '61			Carroll L. Kress					
Raymond J. Fisch														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after

death. Page 4 may be retained by the hospital or attending physician.
GENERAL DIRECTOR: After this certificate has been signed by the attending physician and countersigned by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3319

CERTIFICATE OF DEATH

03367

1. PLACE OF DEATH
a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

c. LENGTH OF STAY IN lb

MARYLAND

80 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

U.S. Naval Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Milton

Edward

4. SEX

6. COLOR OR RACE

7 MARRIED NEVER MARRIED

8 DATE OF BIRTH

4-6-00

Miles

Last

4

DATE
OF
DEATH

Month

Day

Year

March

25

1961

Male

Caucasian

WIDOWED

DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Officer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE County & State, or foreign country

13. FATHER'S NAME

George A. Miles

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give rank or dates of service)

yes 1918 to 1958

16. SOCIAL SECURITY NO., 17. INFORMANT

Arizona

14. MOTHER'S MAIDEN NAME

Mae Cook

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

177X DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause first. (b)

DUE TO

(c)

Carcinoma Prostate wife

metastasis

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED?
YES NO

20a. ACCIDENT WAS UNDERLYING

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED

While at work Not While at work

20e. PLACE OF INJURY (Home, farm factory, street, offce bldg., etc.)

20f. CITY OR TOWN

(County)

(State)

21. I certify that (this hospital) attended the deceased from Jan 4, 1961, to Mar 25, 1961, that (we) last saw the deceased alive on March 25, 1961, and that death occurred at 850PM from the causes and on the date stated above.

22a. SIGNATURE

S.T. Knappenberger

22c. PHYSICIAN'S NAME (Type)

Knappenberger, S.T., LT, MC, USNR

M.D.
ATTENDING
PHYS.

M.D.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED
3-25-61

22d. ADDRESS

U.S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

3-28-61

23c. NAME OF CEMETERY OR CREMATORIUM

Arlington National Cemetery

23d. LOCATION (City, town or county)

(State)

24. OWNER'S OR DIRECTOR'S SIGNATURE

R.A. Pumphrey

ADDRESS

Bethesda, Maryland

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

MAR 28 '61

Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

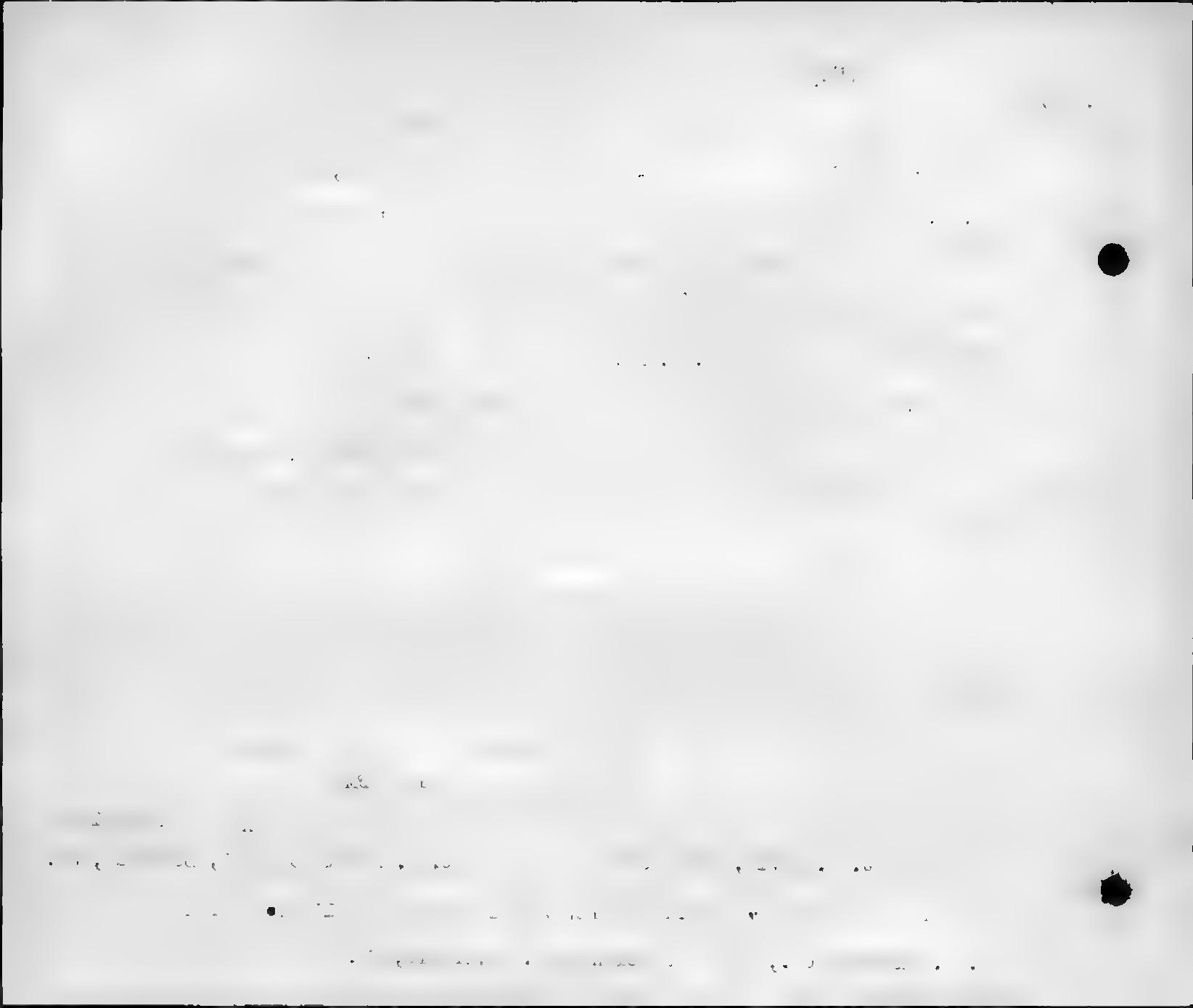
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3320

03348

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hyattsville, Md.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. LENGTH OF STAY IN 1b <u>13 Days</u>	
d. NAME OF HOSPITAL OR INST. TUT ON (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nicholas</u>		First	Middle
4. SEX <u>Male</u>		5. COLOR OR RACE <u>Caucasian</u>	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-12-02</u>	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Enlisted</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>	
11. BIRTHPLACE County & State, or foreign country <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John F. Molloy</u>		14. MOTHER'S MAIDEN NAME <u>Mary Horton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> yes		16. SOCIAL SECURITY NO. 17. INFORMANT <u>(W) Margaret Olive Molloy</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO } (c) DUE TO		Address INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
Carcinoma of the Stomach			
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART Ia)			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 12</u> , 19 <u>61</u> to <u>March</u> , 19 <u>61</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>March 25</u> , 19 <u>61</u> , and that death occurred <u>1912</u> from the causes and on the date stated above.			
22e. SIGNATURE <u>John W. Davis, LT MC USN</u>		22b. DATE SIGNED <u>26 March 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. W. DAVIS, LT MC USN</u>		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>
23e. BURIAL/CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 29, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>Arlington National Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Arlington Virginia</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO.,</u>		25e. REC'D BY REGISTRAR <u>Mar 28 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur J. Kline</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon paper, ages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3321

03309

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

U. S. Naval Hospital

3. NAME OF
DECEASED
(Type or print)

First
Mary

Middle
Patricia

MOORE

5. SEX

Female

6. COLOR OR RACE
Negro

7. MARRIED
WIDOWED

NEVER MARRIED
D.VORCED

8. DATE OF BIRTH
3-17-61

13. FATHER'S NAME

William Ferrell MOORE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

None

(F) Wm. F. Moore, same as #2 above

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause first.

(b)

DUE TO

(c)

Immaturity
Prematurity

(1 lb. 8 oz.)

INTERVAL BETWEEN
ONSET AND DEATH

36 hrs.

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While at work
p.m. 19 Not White
at work

20d. INJURY OCCURRED
at work

20e. PLACE OF INJURY Home, farm,
factory, street, office bldg., etc.

20f. (City or town)

(County)

(State)

21. I certify that (x) (this hospital) attended the deceased from March 17, 1961 to March 18, 1961, that (x) (we) last saw the deceased alive on March 18, 1961, and that death occurred at ... M, from the causes and on the date stated above.

22e. SIGNATURE

Fred W. Grecco

M.D.

ATTENDING
PHYS.

□

MED
DIRECTOR

□

STAFF
PHYS.

22b. DATE
SIGNED
3-19-61

22c. PHYSICIAN'S
NAME (Type)

Fred W. GRECCO, LT, MC, USN

U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORI

23d. LOCATION (City, town or county)

(State)

Burial

3-21-61

Mt. Olivet Cemetery

Washington, D. C.

24. FUNERAL DIRECTOR'S SIGNATURE

Pope Funeral Home, 414 15th St., SE, WashDC

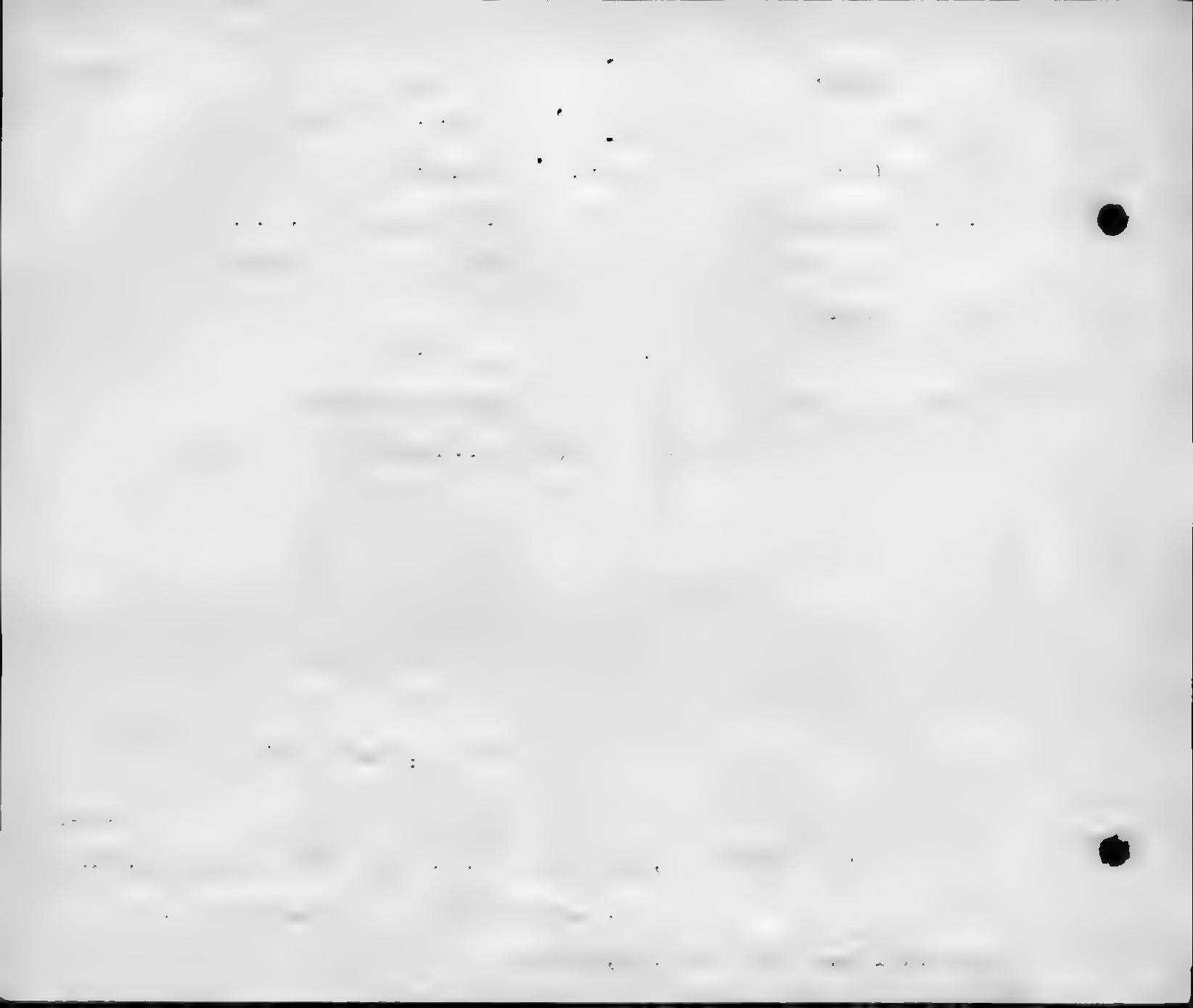
ADDRESS

25a. REC'D BY REGISTRAR

MAR 21 '61

25b. REGISTRAR'S SIGNATURE

Oliver S. Krause



**FOR STATE
HEALTH DEPT.**

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

332 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

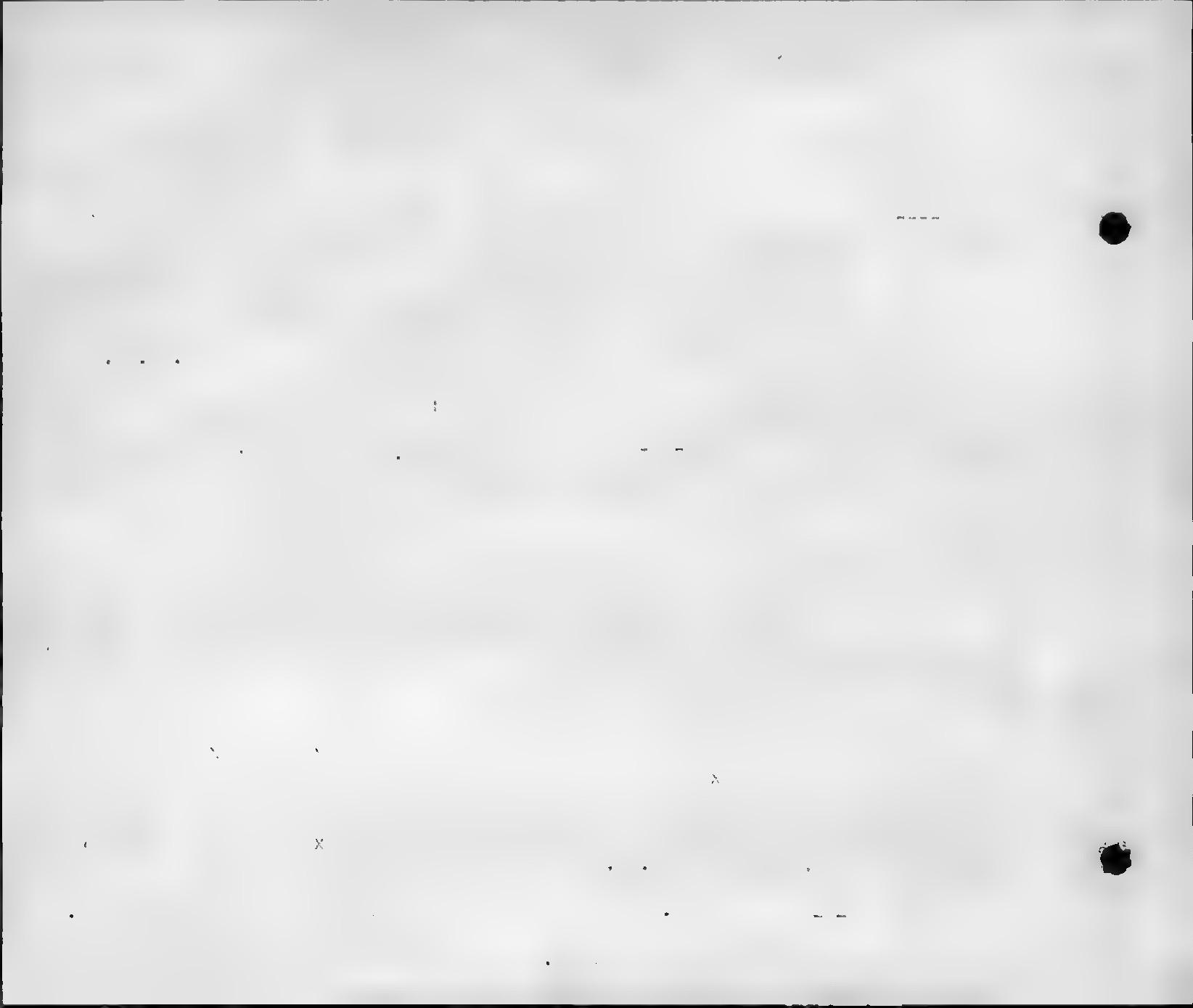
03310

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE	
MONTGOMERY		MARYLAND	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN TB	
ETCHISON		ETCHISON	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<i>Gatheryburg R-2</i>			
3. NAME OF DECEASED (Type or Print)	RUSSELL	GORMAN	MONTGOMERY
4. SEX	MALE	WHITE	5. COLOR OR RACE
6. MARRIED	X	NEVER MARRIED <input type="checkbox"/>	7. MARRIED
8. DIVORCED	<input type="checkbox"/>	9. DATE OF BIRTH	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FARMER	Farm	12/31/1896	10b. KIND OF BUSINESS OR INDUSTRY
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
LUTHER JAMES MOORE	LYDIA EDNA WARFIELD		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give rank or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	217-36-6466	FAMILY Mrs. Russell Moore Same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
CORONARY OCCLUSION			
DUE TO			
Conditions, if any, which gave rise to immediate cause } (b)			
DUE TO			
(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)	
(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>			
EXAMINER'S NAME (Type) FRANK J. BROSCART, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial 3-9-61		Mt. Tabor	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or country)	
ADDRESS		(State)	
23. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR	
<i>Francis H. Barber Laytonsville, Md.</i>		24b. REGISTRAR'S SIGNATURE	
DATE MAR 9 '61		<i>Arthur S. Krause</i>	
DATE			

O DEPUTY MEDICAL EXAMINE: This certificate should be executed within 24 hours after death. If any delay is necessary, please initial the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

O FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5. A15ME
5M 7/59



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO THE GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by him, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3323

CERTIFICATE OF DEATH

03311

1. PLACE OF DEATH

e. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

d. NAME OF HOSPITAL OR INST. TUT. ON (if not in hospital, give street address)

U.S. Naval Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Fred

Mandell

5. SEX

Male

6. COLOR OR RACE

Negroid

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

11-4-60

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Child

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Maryland

13. FATHER'S NAME

Fred Mandell MORRIS Sr.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Barbara Aloneze DYKES

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

None (F) Fred M. Morris, same as #2 above

meningitis

encephalitic cysts

INTERVAL BETWEEN
ONSET AND DEATH

7 DAYS

3 MOS.

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 19

20d. INJURY OCCURRED
While at work Not While
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (this hospital) attended the deceased from **12-14-**, 19**60** to **3-3-**, 19**61** that (we) last saw the deceased alive on **3-3-**, 19**61**, and that death occurred **10:28 PM** from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

Robert V. RACK, LT, MC, USN

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED
3-3-61

22d. ADDRESS

U.S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial 3-8-61

23c. NAME OF CEMETERY OR CREMATORIUM

WOODLAWN

23d. LOCATION (City, town or county)

(State)

S.E. WASHINGTON D.C.

24. FUNERAL DIRECTOR'S SIGNATURE

John T. STEWART

25a. REC'D BY REGISTRAR

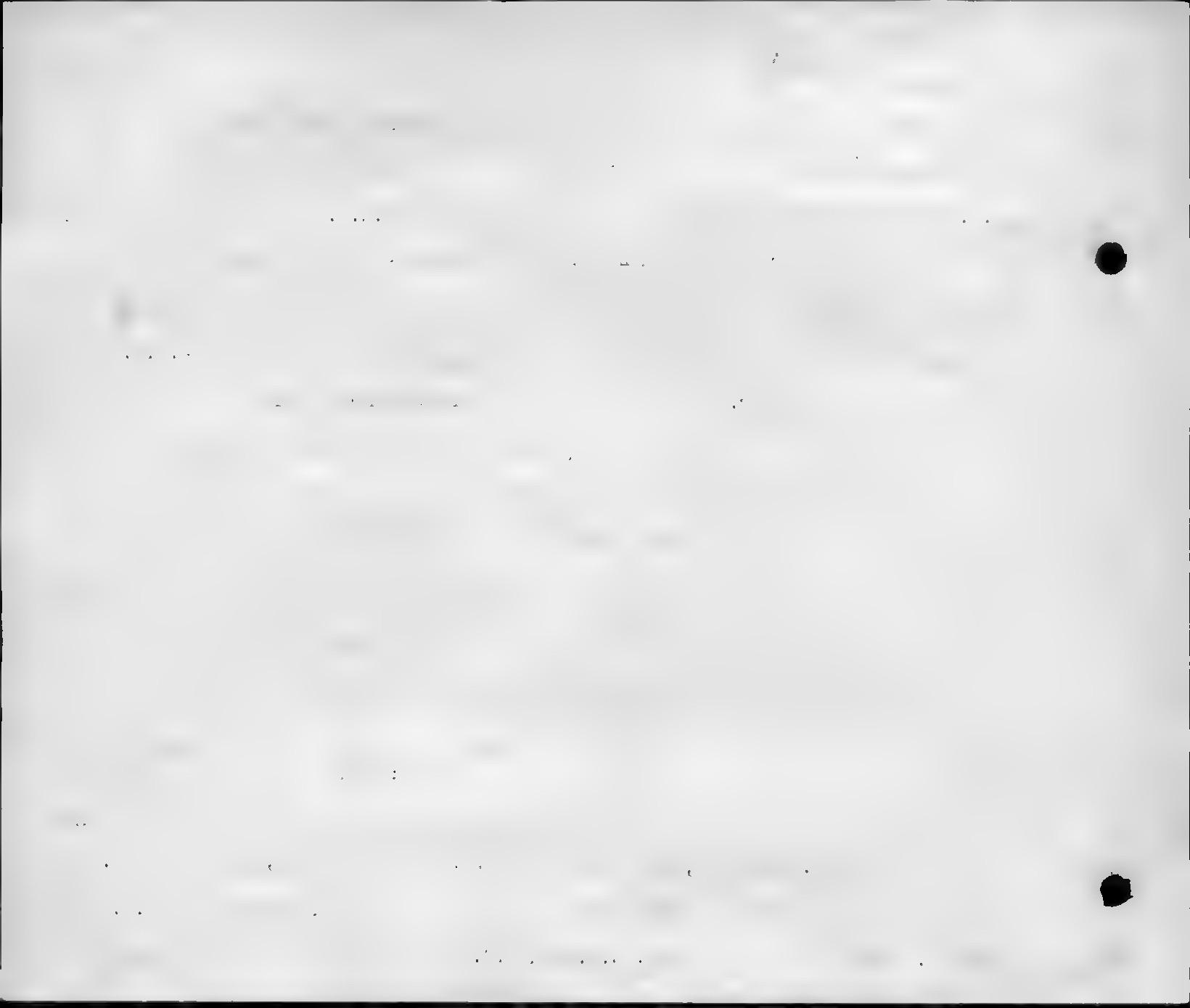
25b. REGISTRAR'S SIGNATURE

DATE

MAR 7 '61

Arthur S. Thomas

VR A15 (4)
15M 460
Gross



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3324

CERTIFICATE OF DEATH

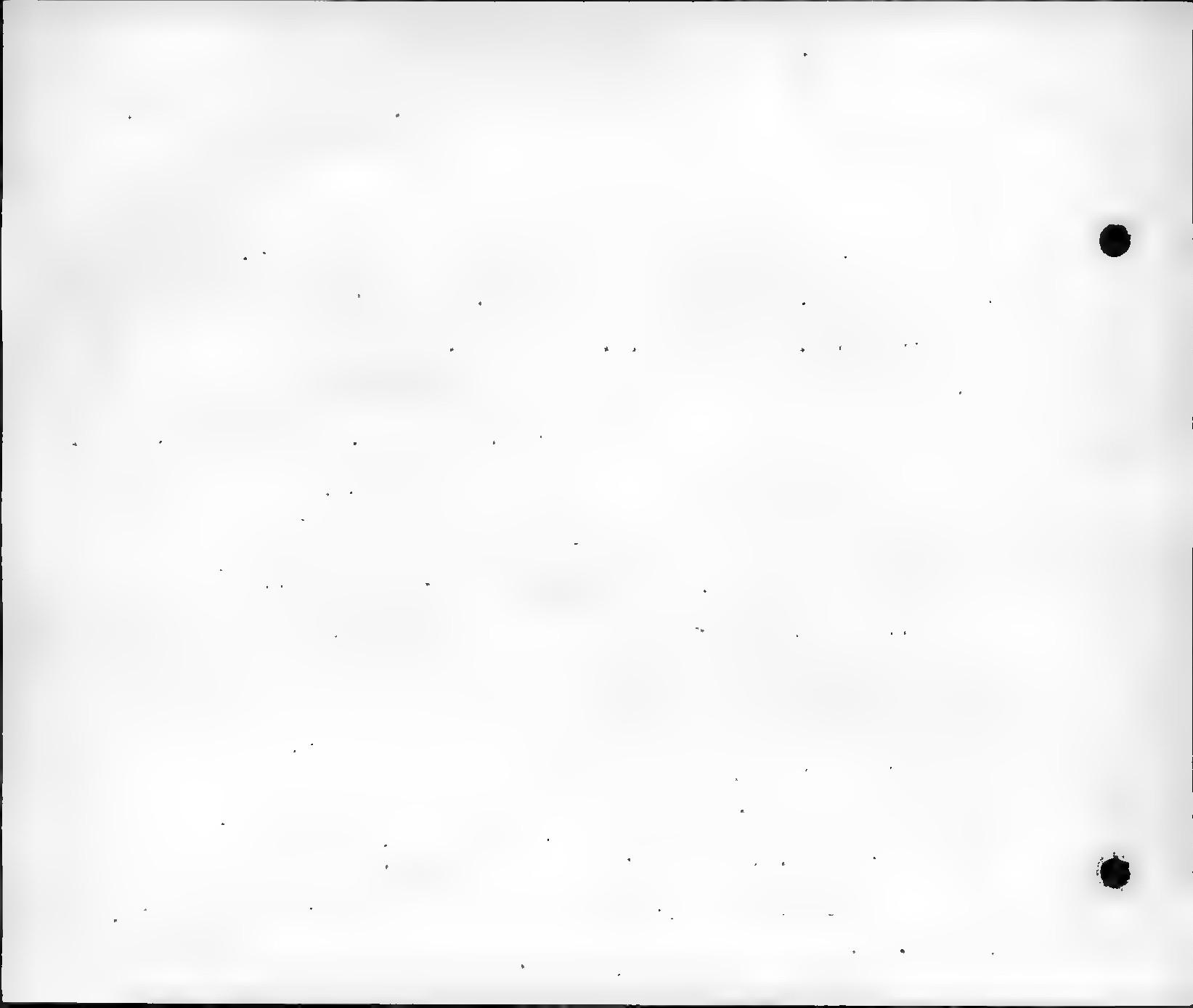
Reg. Dist. No.

03312

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Mont.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood		c. LENGTH OF STAY IN 1b Life		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood		e. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Thomas	Middle Trail	Last Mullican	4. DATE OF DEATH	Month March 10	Day 10	Year 1961
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11, 1870		9. AGE (In years last birthday) 91 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rail road emp.		10b. KIND OF BUSINESS OR INDUSTRY B&O R.R.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Mullican				14. MOTHER'S MAIDEN NAME Rachel Trail				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		INFORMANT Mrs. Bertie M. Hagan -Derwood, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		one hour						
2. <i>2/11/61</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		<i>Coronary thrombosis</i>						
DUE TO (b)		<i>Diabetes mellitus</i>						
DUE TO (c)		<i>Hypertension arteriosclerotic heart disease</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		2 years						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>APRIL 24, 1956</i> to <i>MARCH 10, 1961</i> , that I last saw the deceased alive on <i>FEBRUARY 20, 1961</i> , and that death occurred at <i>2:45 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED						
ACTUAL SIGNATURE <i>Gordon S. Rosenberger</i>		310 West Montgomery Ave. 3/10/61						
PHYSICIAN'S NAME (Type) Gordon S. Rosenberger		Rockville, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-13-61		22c. NAME OF CEMETERY OR CREMATORIUM Forest Oak		22d. LOCATION (City, town, or county) (State) Gaithersburg, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Francis H. Barber</i>		ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR MAR 14 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3325

CERTIFICATE OF DEATH

103313

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

c. LENGTH OF STAY IN TB

3 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

U. S. Naval Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Judith

Ann

5. SEX

6. COLOR OR RACE

Female

Caucasian

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

13. FATHER'S NAME

Ralph E. NICHOLS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or grade of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

None

14. MOTHER'S MAIDEN NAME

Jewel Dean DOWNING

Address

MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.

20d. INJURY OCCURRED
White at work Not White at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (this hospital) attended the deceased from March 21, 1961 to March 24, 1961 that (we) last saw the deceased alive on March 24, 1961, and that death occurred at _____, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

Lawrence G. THRONE, LT, MC, USN U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial-Shipment 3-25-61

23c. NAME OF CEMETERY OR CREMATORIUM

Perry Mount Cemetery

23d. LOCATION (City, town or county)

(State)

Pontiac Michigan

24. FUNERAL DIRECTOR'S SIGNATURE

R.A. Pumphrey cpe
R.A. Pumphrey Funeral Home

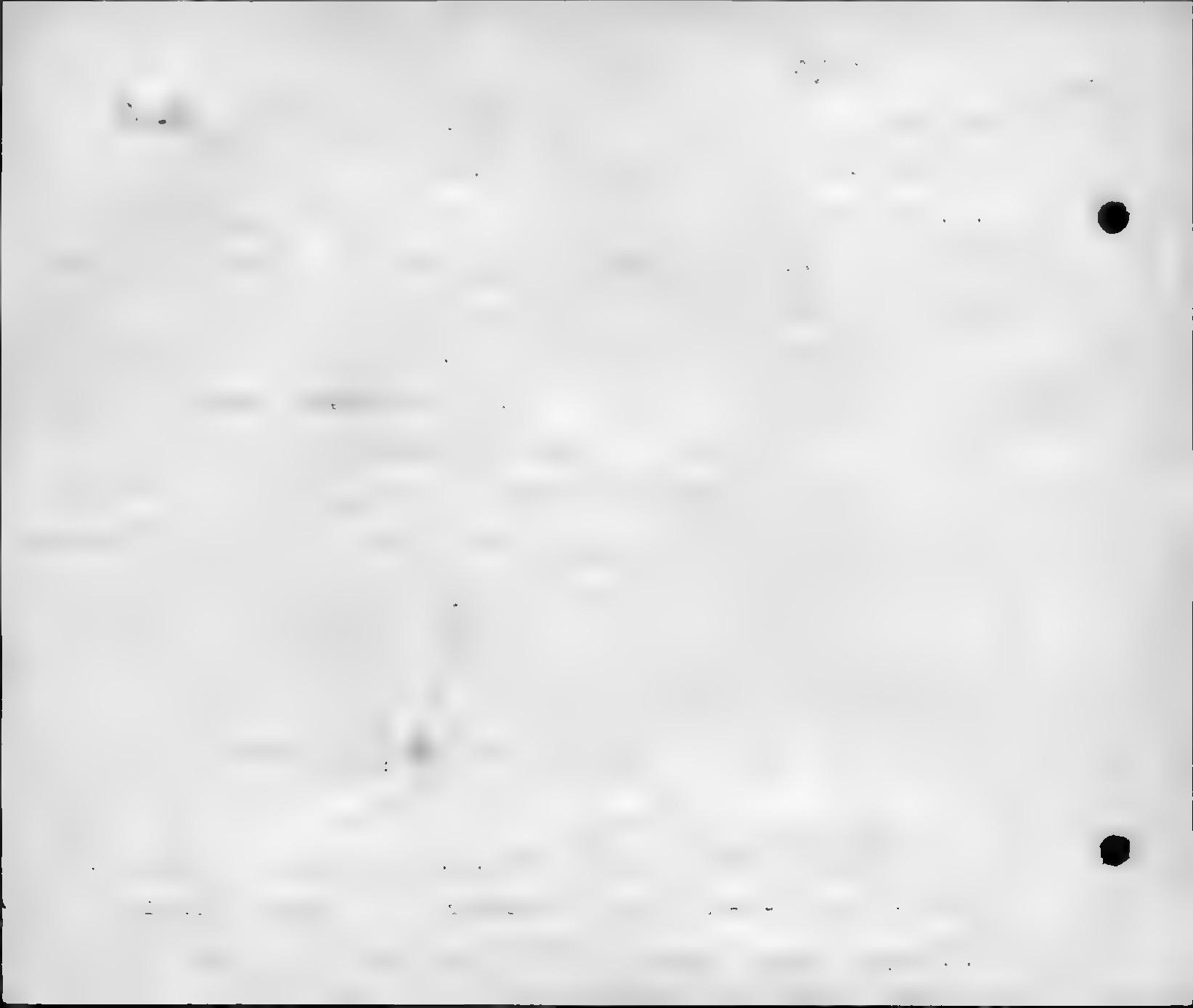
ADDRESS

Bethesda, Md. 7557 Wisconsin Ave. DATE MAR 28 '61

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



FOR STATE
HEALTH DEPT.

M

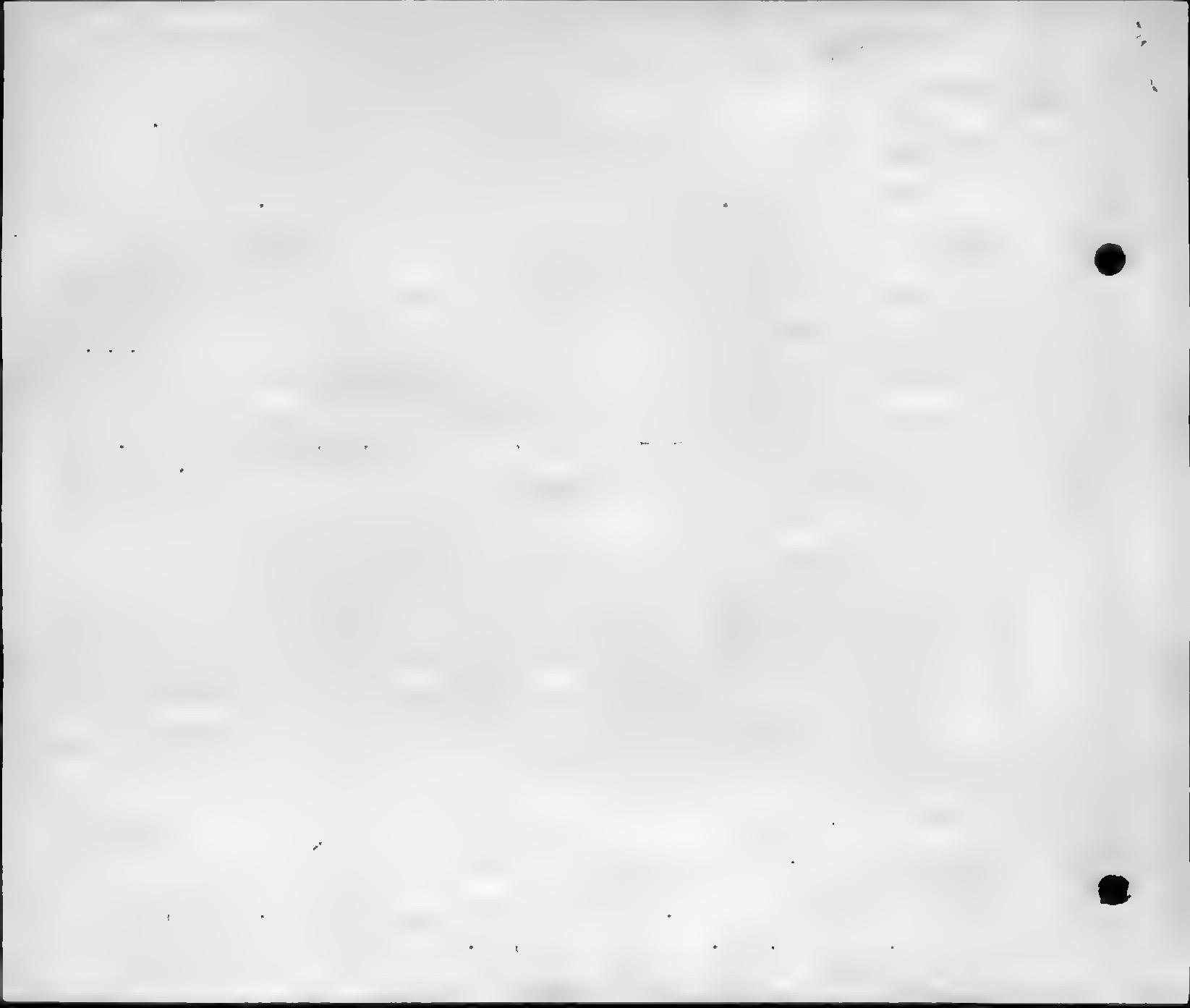
DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3326 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03314

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)	
a. COUNTY		b. STATE	
Montgomery		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
Silver Spring		Montg.	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
12 years		Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
10412 Edgewood Ave.		10412 Edgewood Ave.	
e. IS RESIDENCE ON A FARM?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Myrtle Whitney Niles			
4. DATE OF DEATH		Month	Day
3/21/61		19	
5. SEX		6. COLOR OR RACE	7. MARRIED
fe male		w hite	<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
			<input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years) IF UNDER 1 YEAR, IF UNDER 24 HRS.	
7/23/1872		8 th birthday	Months Dey Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
Homemaker		Iowa	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
FRANCIS WHITNEY		REBECCA NETHERCUTT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT	
NO		261-14-5955 Mrs. Peggy Niles, 10,412 Edgewood Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Silver Spring, Md.	
420.1		INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I e			
History of hypertension and CVA about 3 years ago			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White Not White at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
FRANK J. BROSCHEIT		DATE SIGNED 3/21/61	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
BURIAL		3/24/61	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
FT. LINCOLN CEMETERY		PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR		ADDRESS	
WARNER E. PUMPKIN, INC.		SILVER SPRING, MD.	
Raymond L. Ziska		24a. REC'D BY REGISTRAR MAR 27 '61	
		24b. REGISTRAR'S SIGNATURE Arthur L. Krause	



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an answer is necessary, please enter it on the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3327

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03315

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

MARYLAND

c. LENGTH OF STAY IN TB

12 hrs

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Suburban Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Bernard Celemore Noyes

4. SEX

M

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

February 7, 1910

9. AGE (In years
last birthday)
51 yrs.

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Michigan

13. FATHER'S NAME

Albert Lagginess

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or details of service)

No

16. SOCIAL SECURITY NO.

Unknown

17. INFORMANT

Wife Esther Noyes

Address

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

201X

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DOE TO

(b)

DJE TO

(c)

Hodgkin's disease

INTERVAL BETWEEN
ONSET AND DEATH

8 yrs

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE *Frank J. Bloschart*

EXAMINER'S
NAME (Type) *Frank J. Bloschart*

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

DATE SIGNED

3-11-61

22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

3-15-61

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORI

Parklawn Cemetery

22d. LOCATION (City, town, or county)

Rockville, Maryland

(State)

23. FUNERAL DIRECTOR

ROBERT A. PUMPHREY

ADDRESS

Bethesda, Md.

24a. REC'D BY REGISTRAR

MAR 17 '61

DATE

24b. REGISTRAR'S SIGNATURE

Walter S. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If page 1 is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please do not sign or stamp page 3.

VS A15 (4)
15M 9/58

BETHESDA
1 Apr 14 61

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3328

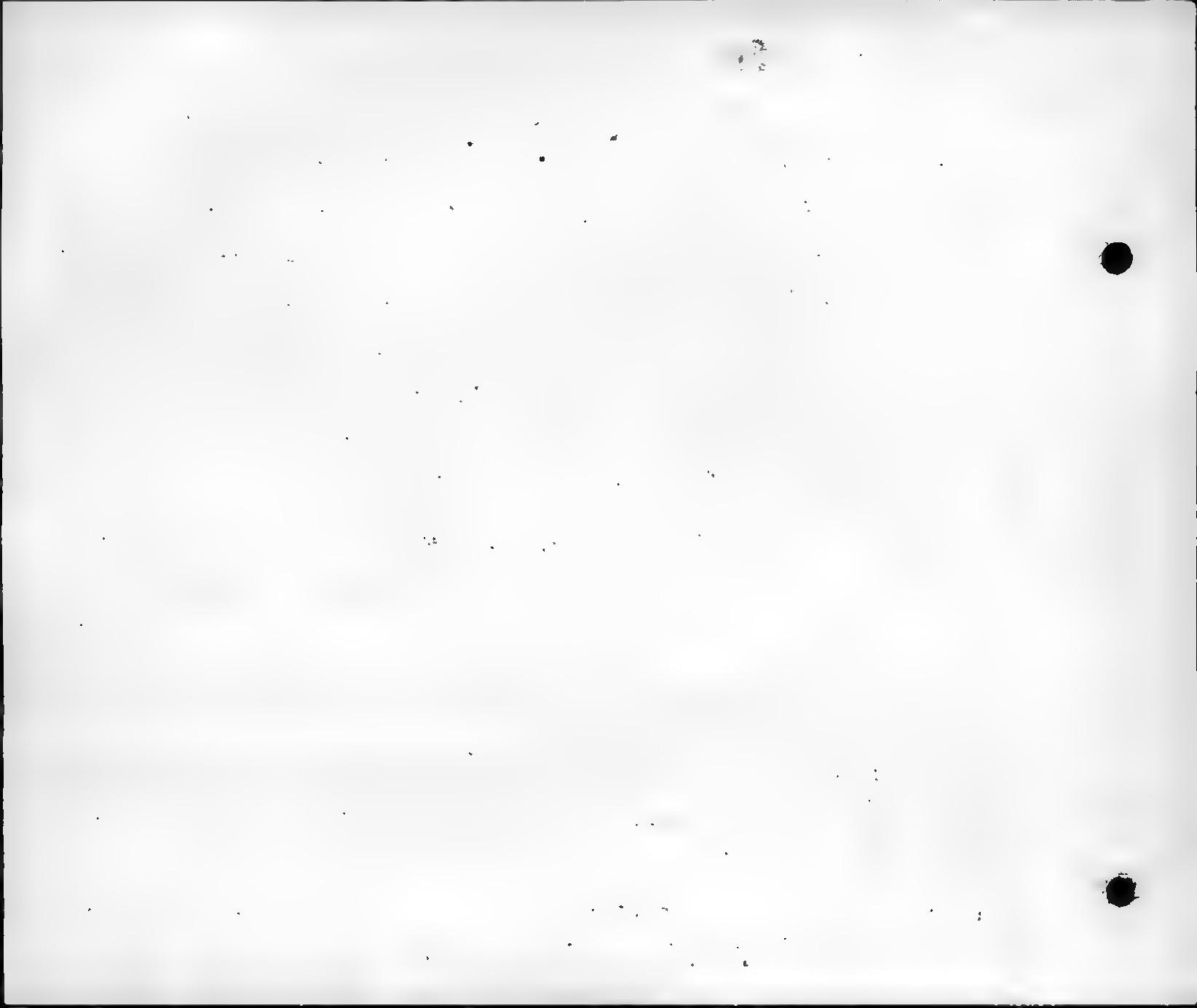
CERTIFICATE OF DEATH

Reg. Dist. No.

03316

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>Baltimore</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BETHESDA</i>		c. LENGTH OF STAY IN lb <i>1 hour</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rickville</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>SUBURBAN HOSPITAL</i>		d. STREET ADDRESS <i>111418 Schuylerland</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Baby</i>	Middle <i>Girl A</i>	Last <i>OAKES</i>	4. DATE OF DEATH <i>MARCH 27, 1961</i>	Month <i>MARCH</i>	Day <i>27</i>	Year <i>1961</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MARCH 27, 1961</i>	9. AGE (In years last birthday) — yrs.	IF UNDER 1 YEAR Months <i>—</i>	IF UNDER 24 HRS. Days <i>—</i>	Hours <i>—</i>	Min. <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		
13. FATHER'S NAME <i>HOWARD HERMAN OAKES</i>		14. MOTHER'S MAIDEN NAME <i>NATALIE ESTELLE Spaid</i>		Address <i>FATHER</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>								
16. SOCIAL SECURITY NO. <i>—</i>		INFORMANT <i>—</i>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) <i>773.5</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO acute hydramnios								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>3/27</u> , 19 <u>61</u> , to <u>3/27</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>3/27</u> , 19 <u>61</u> , and that death occurred at <u>7:30</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>M.D. 1150 Connecticut Ave. N.W. WASH DC</i>								
DATE SIGNED <i>—</i>								
ACTUAL SIGNATURE <i>J E Renshaw</i>								
PHYSICIAN'S NAME (Type) <i>Josephine E Renshaw MD</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		22b. DATE THEREOF <i>3-28-61</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>SUBURBAN HOSPITAL</i>		22d. LOCATION (City, town, or county) <i>BETHESDA, MARYLAND</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Amelia Carter, (per 3B.) Suburban Hospital, Bethesda, Maryland</i>		ADDRESS <i>Suburban Hospital, Bethesda, Maryland</i>		24a. REC'D BY REGISTRAR <i>APR 3 '61</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Price</i>		

- 2174303 X VI



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3329

CERTIFICATE OF DEATH

Reg. Dist. No 03317

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if instit on Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb <i>45 minutes</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>		d. STREET ADDRESS <i>11418 Schuykill rd 1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Baby</i>	Middle <i>Girl</i>	Last <i>"B" Oakes</i>	4. DATE OF DEATH <i>MARCH 27 1961</i>	Month <i>MARCH</i>	Day <i>27</i>	Year <i>1961</i>

5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MARCH 27 1961</i>	9. AGE (In years lost birthday) — yrs — months — days — hours — min	10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>

13. FATHER'S NAME <i>Howard Roy Oakes</i>	14. MOTHER'S MAIDEN NAME <i>Natalie Estelle Spaid</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO —	INFORMANT <i>Father</i>	Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Premature labor</i> DUE TO <i>773.5</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO <i>acute hydramnios</i> (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Doy Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) ADDRESS (Street, city or town, state)	(County)	(State)

21. I certify that I attended the deceased from <i>3/27 1961</i> , to <i>3/27 1961</i> , that I last saw the deceased alive on <i>3/27 1961</i> , and that death occurred at <i>7:30 AM</i> , from the causes and on the date stated above.	DATE SIGNED
ACTUAL SIGNATURE <i>J. E. Renshaw</i>	ADDRESS (Street, city or town, state) <i>1150 Connecticut Ave NW Washington DC</i>

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>3/28/61</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Suburban Hospital</i>	22d. LOCATION (City, town, or county) <i>Bethesda Md.</i>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Amelia Carter (certified)</i>	ADDRESS <i>Suburban Hospital</i>	24a. REC'D BY REGISTRAR DATE <i>APR 3 '61</i>	24b. REGISTRAR'S SIGNATURE <i>Clinton S. Thomas</i>	



may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely
polysigned, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Permit 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND												03318			
3330 CERTIFICATE OF DEATH															
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY Co.</u> MARYLAND												2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b												d. STREET ADDRESS <u>11901 ANDREW ST</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11901 ANDREW ST</u>												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>T</u> Middle <u>OGLE</u>												4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1961</u>			
5. SEX <u>MALE</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>												8. DATE OF BIRTH <u>10/23/1881</u> , 9. AGE (In years last birthday) <u>79 yrs</u> IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child Decorator</u>												10b. KIND OF BUSINESS OR INDUSTRY <u>11. BIRTHPLACE (State or foreign country)</u> <u>WASHINGTON, D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>WILLIAM T. OGLE - SR.</u>												14. MOTHER'S MAIDEN NAME <u>MARGARET DUNN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>												16. SOCIAL SECURITY NO. <u>17. INFORMANT</u> <u>MRS. MARGARET M. OGLE</u> Address <u>11901 ANDREW ST.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <u>Gastro intestinal hemorrhage</u> 4 days															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>generalized arterio Sclerosis - cerebrovascular accidents</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>fall of</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>												20d. INJURY OCCURRED <u>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</u> <u>20f. (City or town) (County) (State)</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 1959</u> to <u>3-19 1961</u> , that (II) (we) last saw the deceased alive on <u>3-17 1961</u> , and that death occurred at <u>1 AM</u> from the causes and on the date stated above															
22a. SIGNATURE <u>Russell M. Tilley, Jr.</u>												M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>3-19-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>RUSSELL M. TILLEY</u>												22d. ADDRESS <u>4701 - Max. Ave N.W. - D.C.</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Mar. 22-1961</u> 23c. NAME OF CEMETERY OR CREMATORIAL <u>Silver Spring - Md.</u>												23d. LOCATION (City, town or county) <u>(State)</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Kettner</u> ADDRESS <u>254 Carroll St. N.W.</u>												25a. REC'D BY REGISTRAR <u>Arthur Kettner</u> DATE MAR 21 '61 25b. REGISTRAR'S SIGNATURE <u>Arthur Kettner</u>			

**FOR
HEALTH**

BY IS NECESSARY

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-hamper permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**VS. A15ME
5M 7/59**

STATE
DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

333 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03313

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN FB

D.O.T.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp tel, give street address)

Wash. SAN & HOSP

First

Middle

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)

e. STATE

Maryland

f. COUNTY

Montgomery

g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

d. STREET ADDRESS

815 9 Stington St

e. IS RESIDENCE ON A FARM?

YES NO 3. NAME OF
DECEASED
(Type or print)

Walter

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

3

7

1961

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

16-22-94

9. AGE (In years
at birthday)

66

Months

Days

Hours

Mn.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Wood WORKER

10b. KIND OF BUSINESS OR INDUSTRY

CABINET MAKING

11. BIRTHPLACE (State or foreign country)

MASS.

13. FATHER'S NAME

OLAF OLSEN

14. MOTHER'S MAIDEN NAME

Gnette Samuelson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give rank or dates of service)

yes 1st-W W.

16. SOCIAL SECURITY NO.

023-12-8089

17. INFORMANT

MR Oliver Olsen

Address

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

Same as
deceasedINTERVAL BETWEEN
ONSET AND DEATH
MINUTES

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute coronary insufficiencyConditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

Severe coronary artery arteriosclerosis

years

DUE TO

(c)

Severe myocardial hypertrophy with clinical hypertension

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART Ia. 19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY Month, Day, Year

Month

Day

Year

Hour

3:30 p.m.

3 - 7

1961

20d. INJURY OCCURRED

While

Not White

at work

at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

factory

street

Silver Spring

Montg. Md.

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner ACTUAL
SIGNATURE

Frank J. Broschart

EXAMINER'S
NAME (Type)

Frank J. Broschart

CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

May 8 1961

Mass.

22e. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

March 10, 1961

22c. NAME OF CEMETERY OR CREMATORIUM

Eastwood Cemetery

22d. LOCATION (City, town, or county)

Lancaster

Mass.

23. FUNERAL DIRECTOR

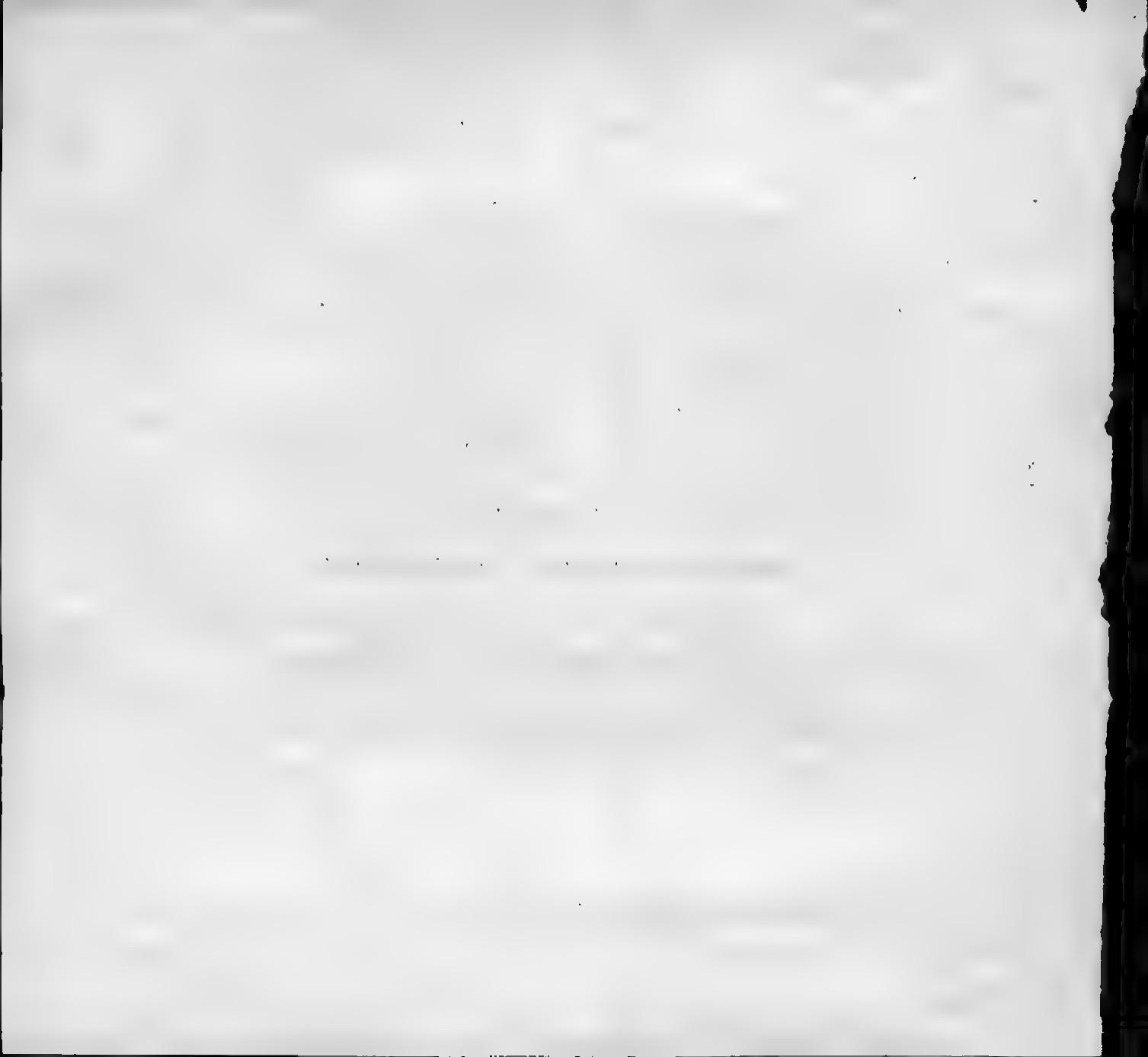
ADDRESS

24a. REC'D BY REGISTRAR

MAR 10 '61

24b. REGISTRAR'S SIGNATURE

Orchard S. Thomas



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1 03320

1. PLACE OF DEATH
a. COUNTY
Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Bethesda (Rural)

c. LENGTH OF STAY IN MD
5 days

MARYLAND

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE
District of Columbia
b. COUNTY

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Washington D. C.

d. STREET ADDRESS
1629 Columbia Rd., Argoone Apt's

e. IS RESIDENCE ON A FARM?
YES NO

3. NAME OF DECEASED (Type or print)
Robert Frank

First Middle

4. DATE OF DEATH
PADGETT | March 18 1961

5. SEX
Male

6. COLOR OR RACE
Caucasian

7. MARRIED **NEVER MARRIED**

8. DATE OF BIRTH
1-14-80

9. AGE (in years last birthday)
81 yrs

F. UNDER 1 YEAR
Months Days Hours Min

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. KIND OF BUSINESS OR INDUSTRY

12. CITIZEN OF WHAT COUNTRY?
Virginia USA

13. FATHER'S NAME
Charles PADGETT

14. MOTHER'S MAIDEN NAME
Margaret Keyes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war dates of service)
Yes

16. SOCIAL SECURITY NO.

17. INFORMANT
Margaret P. STEPHAN 5304 Elliott Rd. Washington 16, D.C.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)
Thrombosis, cerebral (left middle cerebral a)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b)
Arteriosclerosis, generalized

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH
6 days

6 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING **CAUSE OF DEATH** (If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) attended the deceased from March 13, 1961 to March 18, 1961, that (I) last saw the deceased alive on March 18, 1961, and that death occurred 6:00PM from the causes and on the date stated above.

22a. SIGNATURE
Russell Miller Jr. LT MC USN

22b. DATE SIGNED
3-19-61

22c. PHYSICIAN'S NAME (Type)
Russell MILLER, Jr. LT, MC, USN

22d. ADDRESS
U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial 3-22-61

23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS
Arlington National Cemetery Arlington, Virginia

23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE
John C. Everly

ADDRESS
Everly-Wheatley Funeral Home, Alexander, Va.

25a. REC'D BY REGISTRAR MAR 21 '61

25b. REGISTRAR'S SIGNATURE
Arthur S. Kline



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may
be
joined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										03321	
3333					CERTIFICATE OF DEATH						
1. PLACE OF DEATH a. COUNTY		Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived — If institution Residence before admission) a. STATE		Mississippi			✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 16 Days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Biloxi		d. STREET ADDRESS 47 West End Homes			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.											
3. NAME OF DECEASED (Type or print)		First Richard	Middle Kenneth	Last Palmer	4. DATE OF DEATH		Month March	Day 1,	Year 1961		
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B DATE OF BIRTH	9. AGE (In years lost birthday) yrs		IF UNDER 1 YEAR	IF UNDER 24 HRS			
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	November 25, 1960	Months 3	Days 6	Hours	Min			
10a. US JAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (State or foreign country) Mississippi			12 CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Kenneth R. Palmer			14. MOTHER'S MAIDEN NAME Dixie Palmer								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No			16. SOCIAL SECURITY NO.			17. INFORMANT The Medical Records Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			Respiratory Failure			INTERVAL BETWEEN ONSET AND DEATH 1 hour					
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost			DUE TO (b) Pulmonary Congestion			12 hours					
			DUE TO Acute congestive failure following aortic-pulmonary anastomosis			24 hours					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)			20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from February 13, 1961, to March 1, 1961, that (1) (we) last saw the deceased alive on March 1, 1961, and that death occurred at 7:35 P.M. The causes and on the date stated above.											
22a. SIGNATURE <i>J. W. Gilbert</i>			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22b. DATE 3/2/61		
22c. PHYSICIAN'S NAME (Type) J. W. GILBERT, M.D.			22d. ADDRESS The Clinical Center National Institutes of Health Bethesda 14, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify) SPHRA 33-1961			23b. DATE THEREOF 3/3/1961			23c. NAME OF CEMETERY OR CREMATORIAL SPHRA			23d. LOCATION (City, town, or county) (State) i.e.,		
24. FUNERAL DIRECTOR'S SIGNATURE L. L. CHAMBERS CO.			ADDRESS 1420 CHAPIN ST.			25a. REC'D BY REGISTRAR DATE MAR 3 '61			25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03382

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please initial the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Gaithersburg

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

426 N. Frederick Ave.

3. NAME OF
DECEASED
(Type or print)

First Middle Last

Samuel Harold Peddicord

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED

 NEVER MARRIED DIVORCED WIDOWED

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Montg.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

d. STREET ADDRESS

426 N. Frederick Ave.

Last

4. DATE
OF
DEATH

Month

Day

Year

March 14

Aug. 27, 1895

65 yrs.

9. AGE (In years
last birthday)IF UNDER 1 YEAR
Months DaysIF UNDER 24 HRS.
Hours Min.10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

gardiner

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

13. FATHER'S NAME

Thomas E. Peddicord

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank and date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

May allen Briggs

Address

Harold U. Peddicord. Rockville, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH

sudden

MEDICAL CERTIFICATION

2Da. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH

2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.20d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from Natural causes Accident Suicide Homicide Undetermined manner CHIEF MEDICAL EXAMINER M.D. ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

DATE SIGNED

Mar. 15, 1961

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Frank J. Broschart

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

Ernest C. Gartner.

ADDRESS

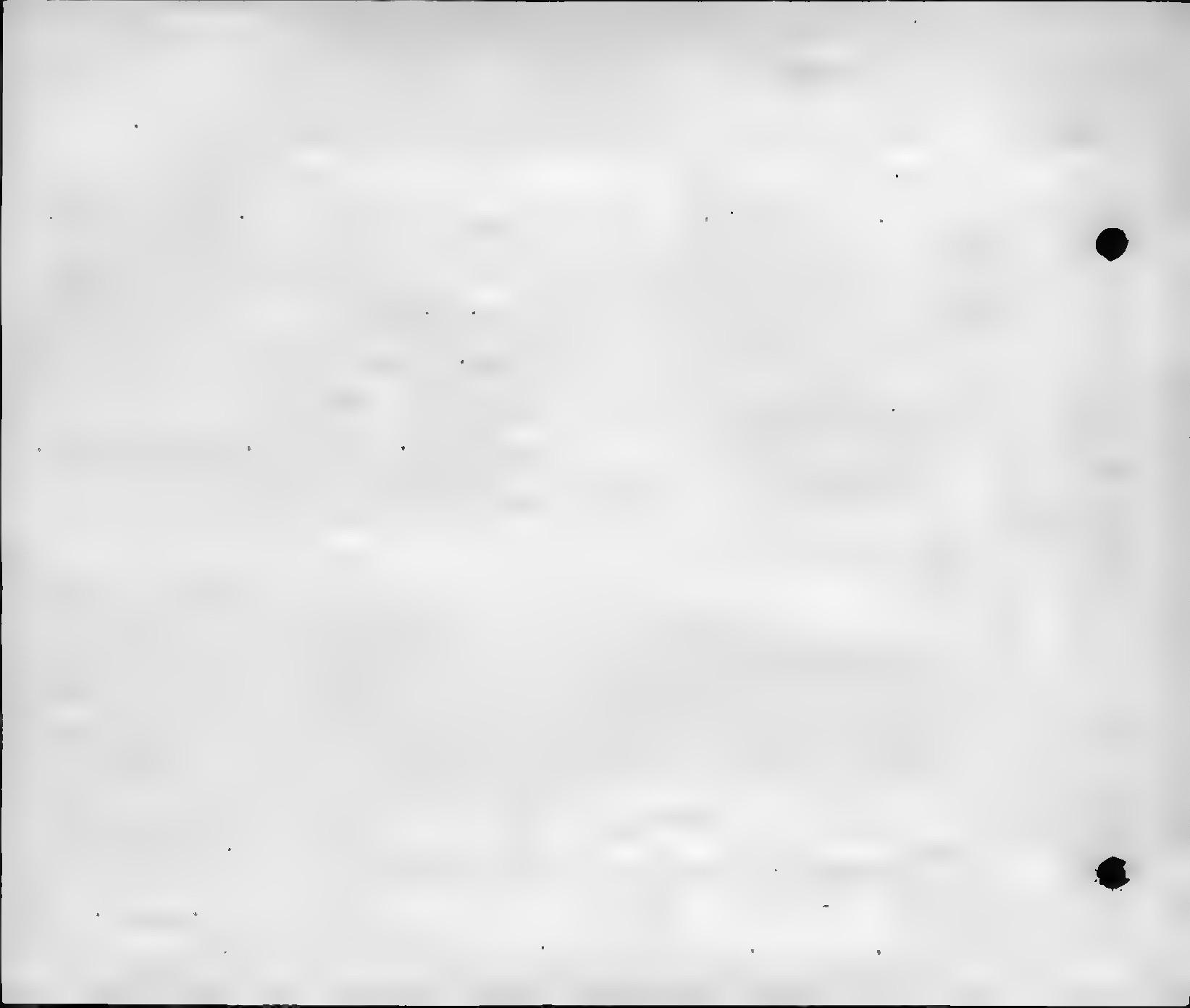
Gaithersburg, Md.

24a. REC'D BY REGISTRAR

DATE MAR 17 '61

24b. REGISTRAR'S SIGNATURE

Arthur & Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certifcate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3335

CERTIFICATE OF DEATH

03323

1. PLACE OF DEATH

a. COUNTY

MONTGOMERY

b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town)

WHEATON

MARYLAND

c. LENGTH OF STAY IN lb

12 DAYS

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

WHEATON NURSING HOME

3. NAME OF
DECEASED
(Type or print)

First

Middle

SHIRLEY

4. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

10/25/1903

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE County & State, or foreign country

RUSSIA

13. FATHER'S NAME

MAYER KERSUN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service)

NO

16. SOCIAL SECURITY NO. 17. INFORMANT

DORA OMINSKY

Address

ISADORE A. PERRY 8031 EASTERN AVE., S.S., MD.

INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a)

CARCINOMATOSIS WITH INVOLVEMENT OF
LEFT PLEURA, LIVER, AND SPLEEN, PRIMARY SITE UNDETERMINED

DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last. } (b)
} DUE TO
} (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 2/6/1961 to 3/29/1961, that (I) (we) last saw the deceased alive on 3/28/1961, and that death occurred at 9:45 A.M. from the causes and on the date stated above.

22a. SIGNATURE

David Goldenberg, M.D.

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

3/29/61
DATE
SIGNED

22c. PHYSICIAN'S
NAME (Type)

DAVID GOLDENBERG M.D.

22d. ADDRESS

10620 GEORGIA SILVER SPRING, MD.

23a. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL 3-31-61

23b. DATE THEREOF

KING DAVID MEMORIAL GARDEN

23c. NAME OF CEMETERY OR CREMATORIUM

FALLS CHURCH

(State)

VA.

24. FUNERAL DIRECTOR'S SIGNATURE

BERNARD DANZANSKY & SONS - 3501-14th ST. N.W.

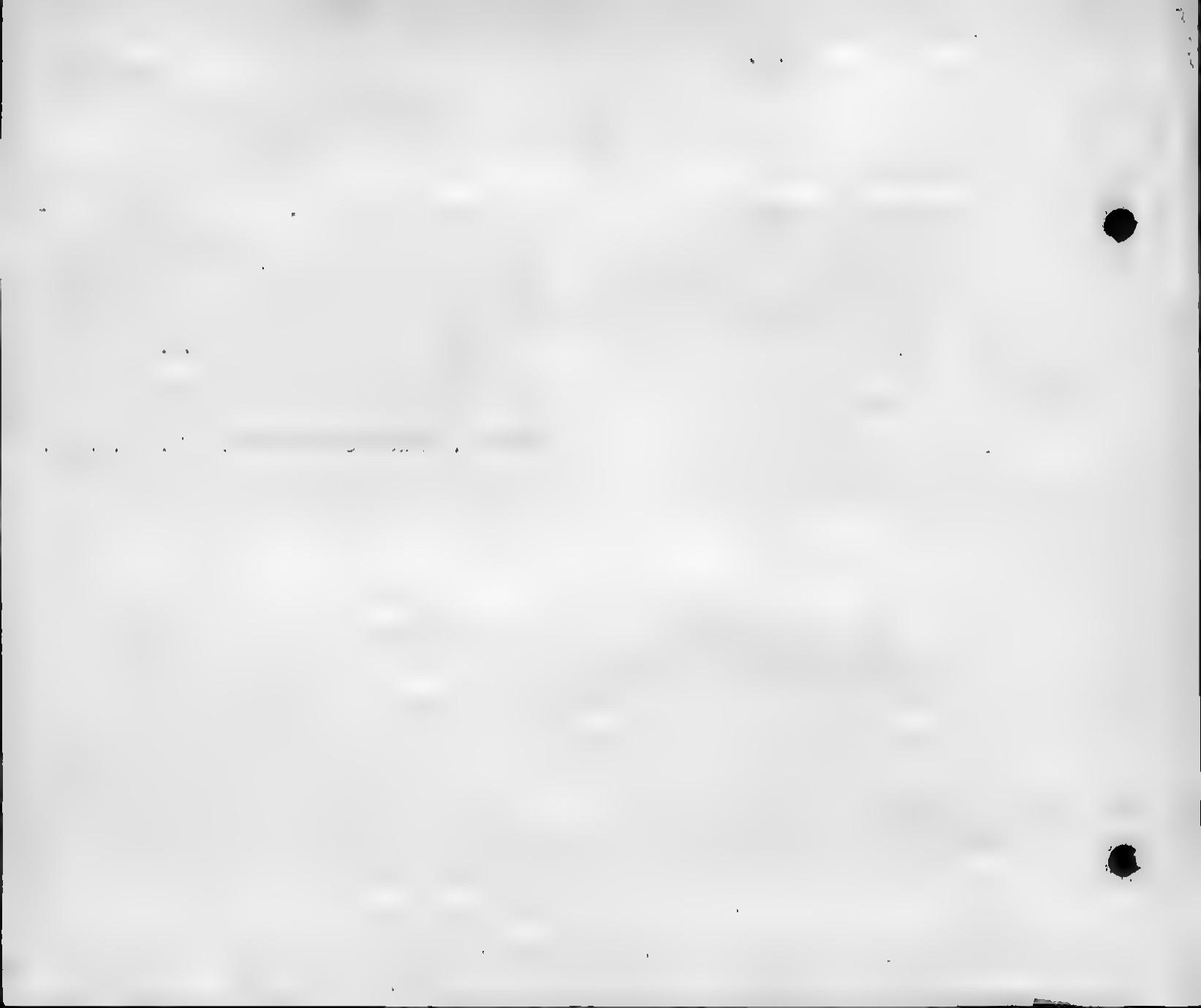
ADDRESS

25a. REC'D BY REGISTRAR APR 3 '61

DATE

25b. REGISTRAR'S SIGNATURE

✓ B. Danzansky



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3336

CERTIFICATE OF DEATH

113324

1. PLACE OF DEATH
• COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN lb

MARYLAND

10 days.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

15 Washington Sanitarium and Hospital

3. NAME OF DECEASED
(Type or print) First Middle

Mabelle

Louise Pfleger

2. USUAL RESIDENCE (Where deceased lived, if institution: Residencia before admission)

a. STATE

Maryland

b. COUNTY

Prince George

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hyattsville

11e
d. STREET ADDRESS

4008 Quintana Street

Last Month Day Year

March 8

4. DATE OF DEATH

Month Day Year

March 8 1961

9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

68 yrs.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Government Employee Bureau Engraving Wisconsin

13. FATHER'S NAME

Charles A. Lanphear

14. MOTHER'S MAIDEN NAME

Margaret Pfuntner

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOC AL SECURITY NO 17. INFORMANT

(Yes, no, or unknown) (If yes give rank, dates of service)

No 215-14-7117 Washington Sanitarium and Hospital

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Myocardial Infarction, Acute
CORONARY

DUE TO
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b) Thrombosis, Acute, LEFT ANTERIOR DESCENDING

(c) Pulmonary Embolism, RIGHT AND LEFT LOWER

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

DIABETES MELLITUS.

20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20f. TIME OF INJURY Month, Day, Year
Hour e.m.
p.m.

20g. INJURY OCCURRED While at work
Not While at work

20h. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
City or town (County) (State)

21. I certify that (I) (this hospital) attended the deceased from FEB 12, 1961, to MAR 3, 1961, that (I) (we) last saw the deceased alive on MAR 1, 1961, and that death occurred at 3:30 AM, from the causes and on the date stated above.

22e. SIGNATURE

22e. PHYSICIAN'S NAME (Type) ROBERT B. IREY

22f. ADDRESS 7105 Riggs Road, Hyattsville, Md.

23a. BURIAL, CREMATION REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL

BURIAL Mar. 11, 1961 National Memorial Park Falls Church, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

W. W. Chambers Jr. 5701 Cleveland Ave. Rockville DATE MAR 13 '61 Clinton S. Thomas

W. W.

MARYLAND STATE DEPARTMENT OF HEALTH

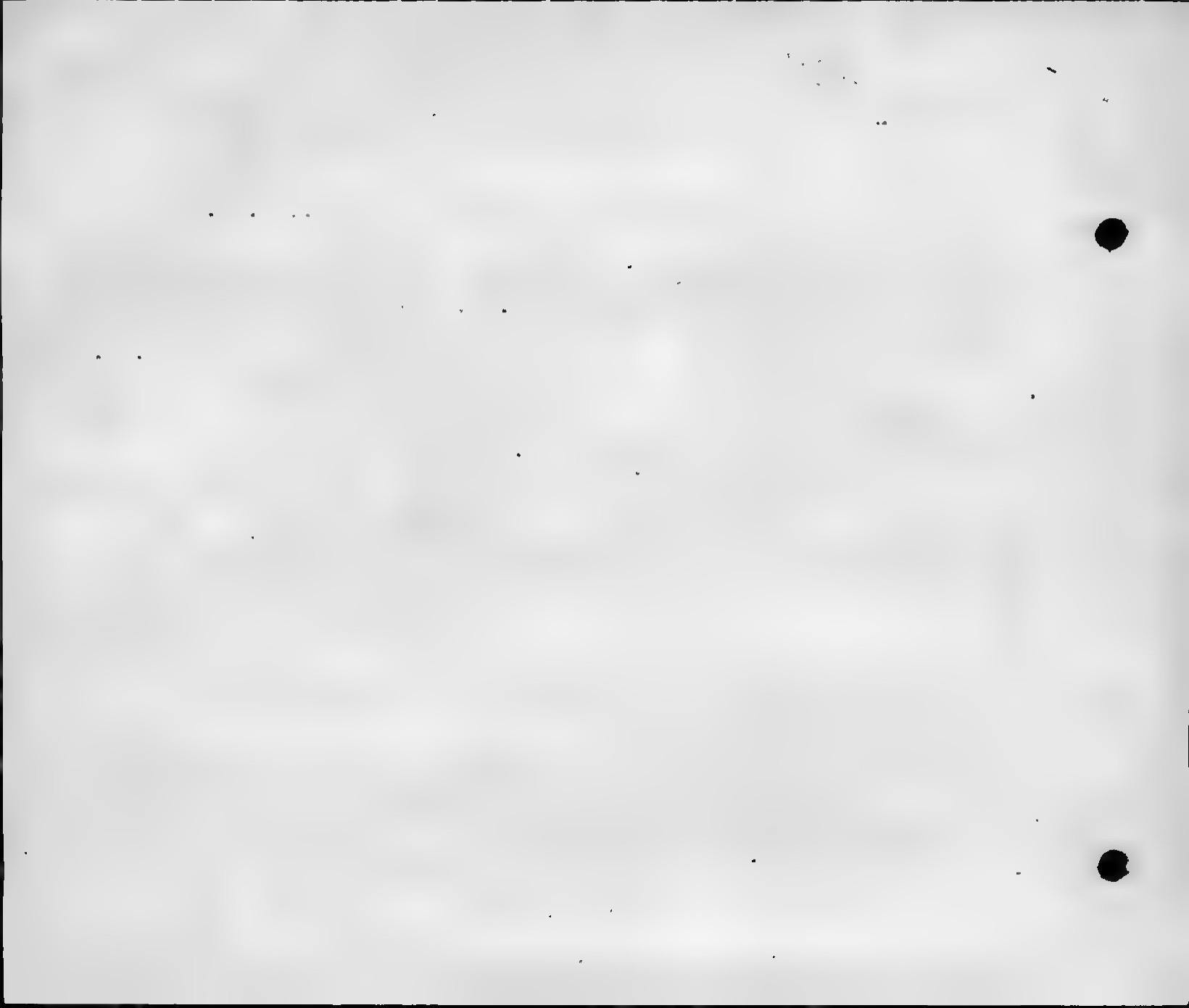
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3337

43325

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
Montgomery		b. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		District of Columbia	
Bethesda		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Washington	
Suburban Hospital		d. STREET ADDRESS	
First Middle		3517 Rodman St., N. W.	
3. NAME OF DECEASED (Type or print)		e. LENGTH OF STAY IN lb	
ALLIEEN		f. LENGTH OF STAY IN lb	
5. SEX		g. LENGTH OF STAY IN lb	
Female		h. LENGTH OF STAY IN lb	
6. COLOR OR RACE		i. LENGTH OF STAY IN lb	
White		j. LENGTH OF STAY IN lb	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		k. LENGTH OF STAY IN lb	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		l. LENGTH OF STAY IN lb	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		11. BIRTHPLACE (County & State or foreign country)	
13. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY?	
Alfred Owens		U. S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT Daughter Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		None Mrs. Frances Hoffheins	
25-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		ACUTE MYOCARDIAL INFARCTION ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 6 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-8 1961 to 3-8 1961, that (I) (was) last saw the deceased alive on 3-8 1961, and that death occurred at _____, from the causes and on the date stated above.		22b. DATE SIGNED 3-9-61	
22c. SIGNATURE <i>Edward W. Youngblood MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Edward W. Youngblood		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		Wisconsin & Western Avenue, Wash D	
23b. DATE THEREOF 3/11/61		(Street)	
23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		23d. LOCATION (City, town or county) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR MAR 14 '61 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>	
ADDRESS Bethesda, Maryland		DATE	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

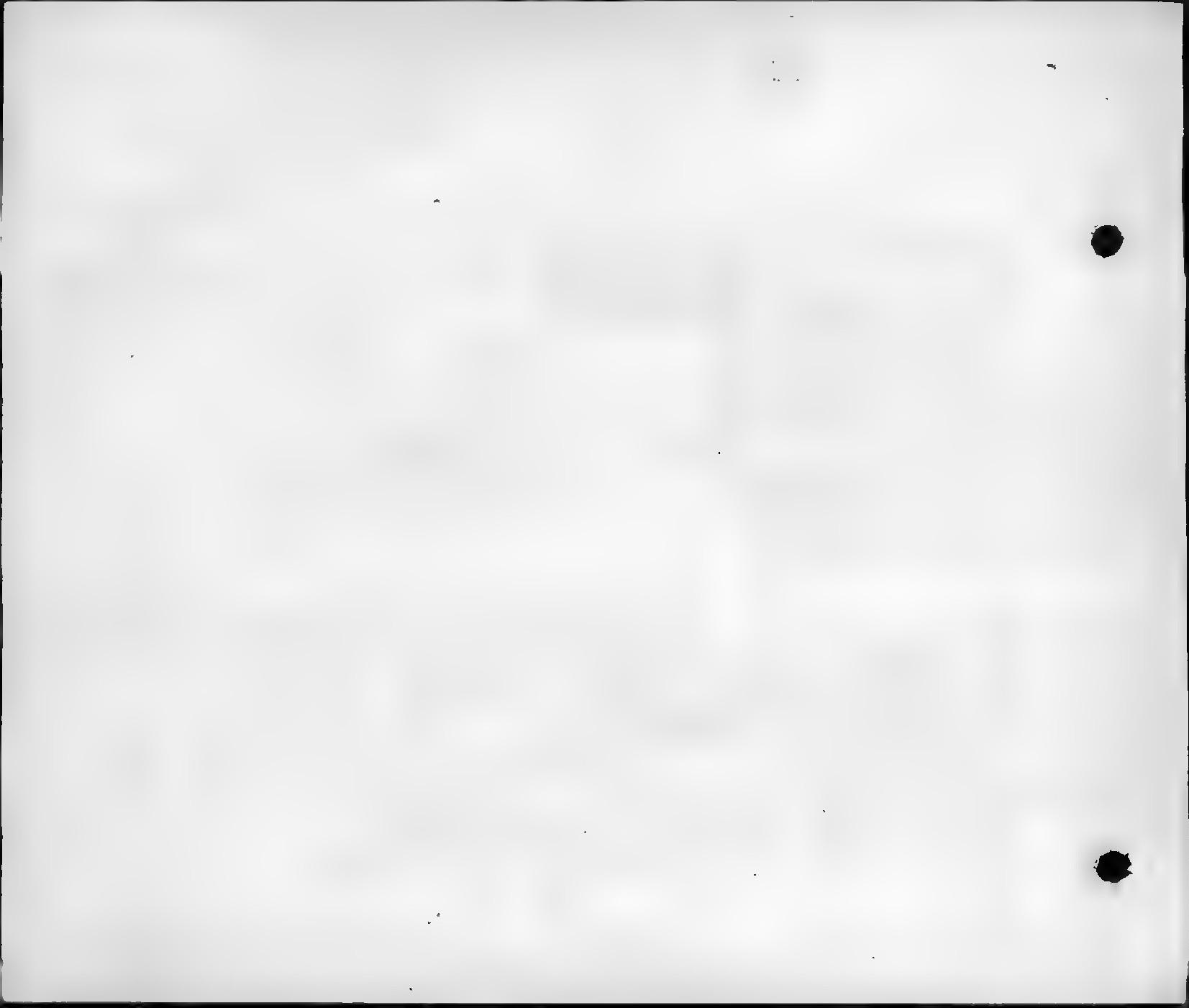
Reg. Dist. No. 03326

3335

Item 7 rilmg 3-17-61 et

DUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours of death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 16		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11112 Mitschner Street		d. STREET ADDRESS 11112 Mitschner Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PATRICIA ANN PHILLIPS		First	Middle	Last	4. DATE OF DEATH Month March Day 8 , Year 1961
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 8, 1925	9. AGE (in years last birthday) 36 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME Clarence Edward Frances		14. MOTHER'S MAIDEN NAME Mannix		12. CITIZEN OF WHAT COUNTRY? U. S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 235-30-1983		17. INFORMANT Sister Mrs. Curran	
Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) Silver Spring (County) Maryland (State) Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 3-8-61	
EXAMINER'S NAME (Type) FRANK J. BROSCHEART					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/11/61		22c. NAME OF CEMETERY OR CREMATORIUM Gate of Heaven Cem.	
22d. LOCATION (City, town, or county) (State) Silver Spring, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland					
24a. REC'D BY REGISTRAR Arthur S. Kraus		24b. REGISTRAR'S SIGNATURE			
DATE MAR 14 '61					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

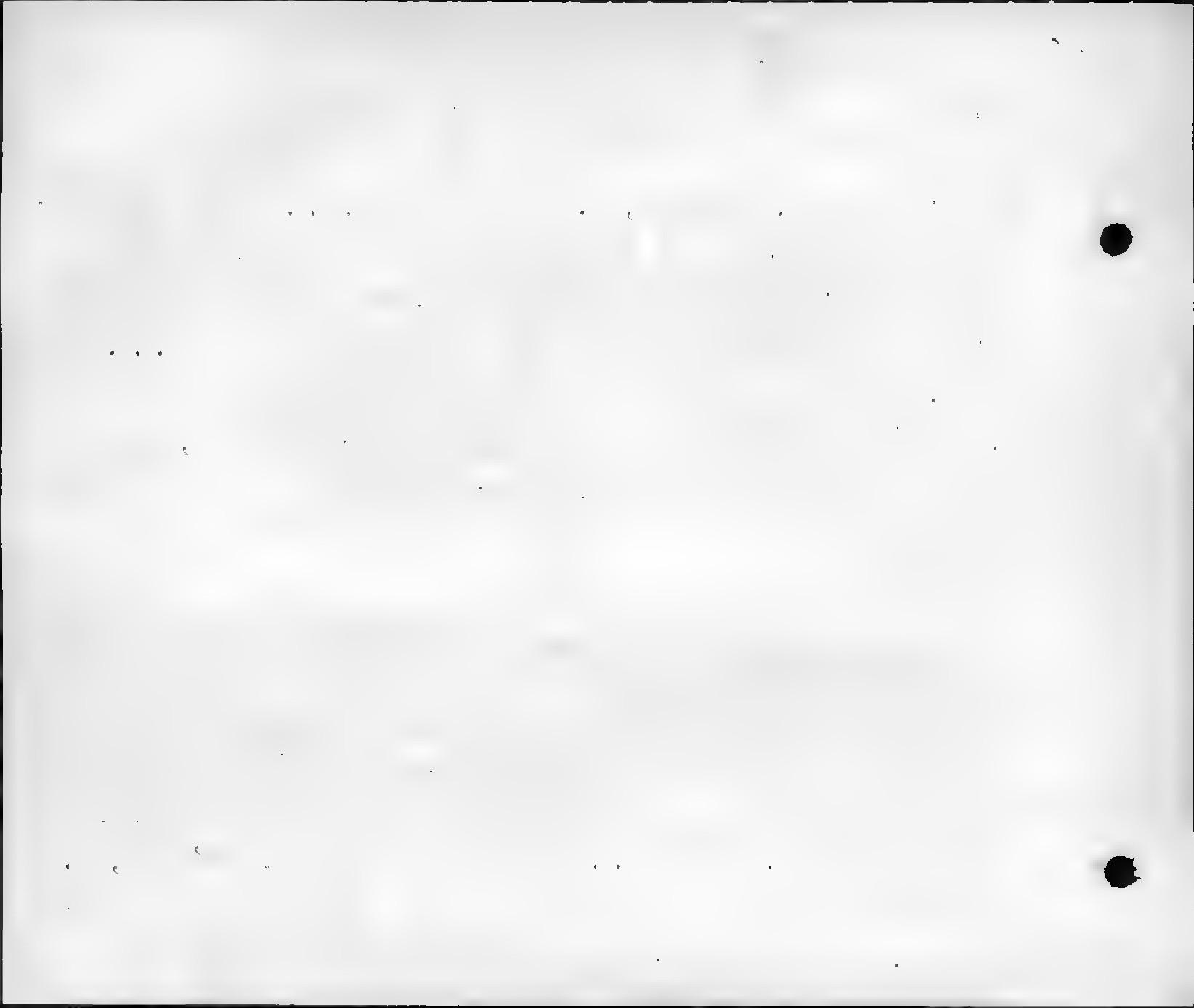
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3339

CERTIFICATE OF DEATH

03327

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE District of Columbia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 61 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 430 Ridge Road, S.E.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Linda	Middle May	Last Phyfer	4. DATE OF DEATH March 29 1961	Month March	Day 29	Year 1961
S SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 18, 1955	9. AGE (in years last birthday) 5 yrs.	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS Days Hours	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bill S. Phyfer				14. MOTHER'S MAIDEN NAME Barbara M. Lowman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown, If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Neuroblastoma, Metastatic to Lungs INTERVAL BETWEEN ONSET AND DEATH 18 Months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO DUE TO DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 27 1961 to March 29 1961 , that (I) (we) last saw the deceased alive on March 29 1961 , and that death occurred 11:40 P.M. from the causes and on the date stated above							
22a. SIGNATURE <i>Robert B. Scoggins, M.D.</i>		ATTENDING PHYS <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) ROBERT B. SCOGGINS, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION REMOVAL (Specify) Burial-Transit		23b. DATE THEREOF 3/31/61		23c. NAME OF CEMETERY OR CREMATORIUM New Albany Cemetery		23d. LOCATION (City, town, or county) (State) New Albany, Mississippi	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE APR 3 '61		25b. REGISTRAR'S SIGNATURE Arthur J. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3340 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

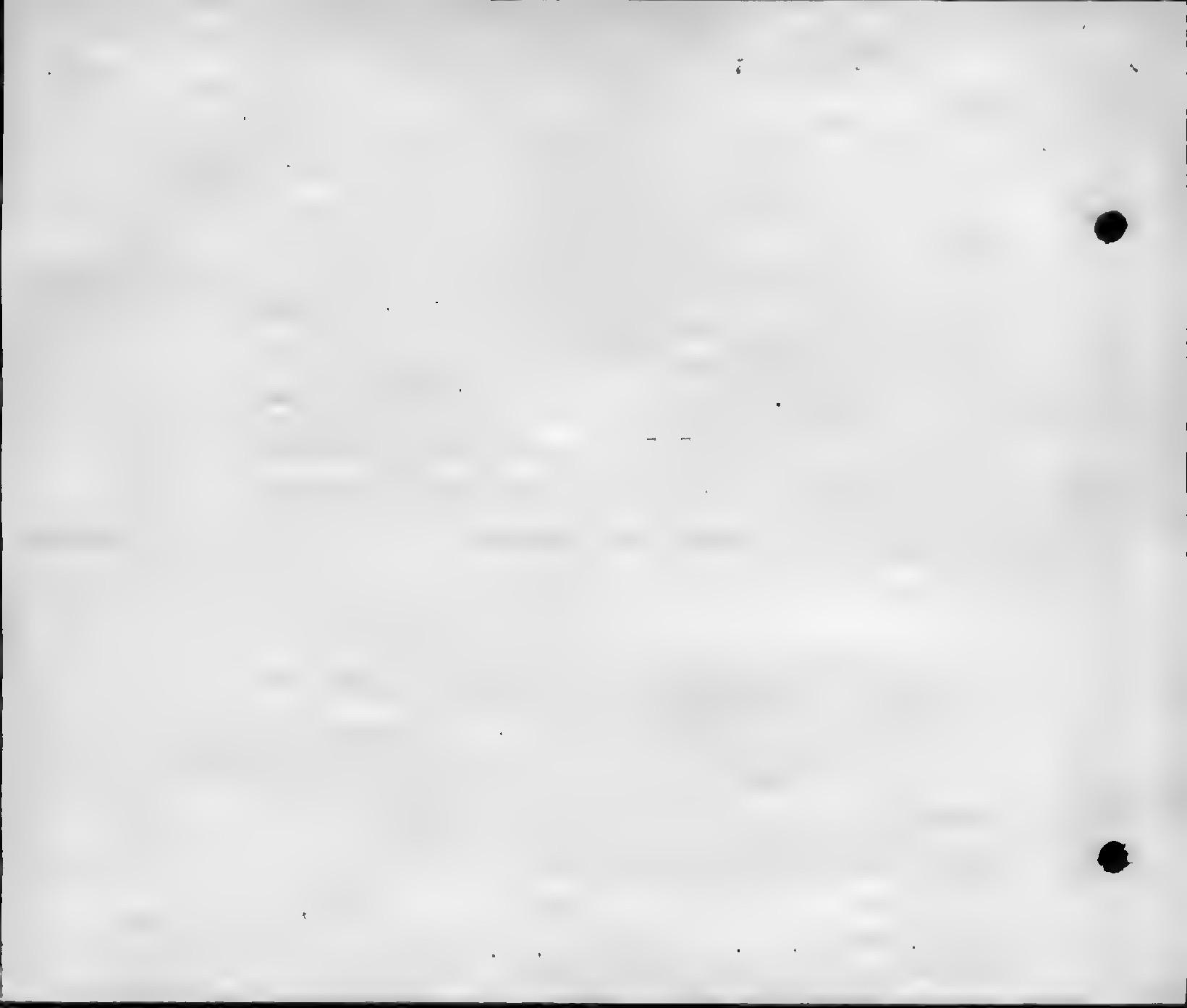
FOR STATE
HEALTH DEPT.

M

May is necessary,
please file the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the
Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. COUNTY <i>Maryland</i>	
b. CITY OR TOWN [If out of corporate limits, write RURAL and give nearest town] <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>2 1/2 min.</i>	
d. NAME OF HOSPITAL OR INSTITUTION [If not in hospital, give street address] <i>Washington Sanitarium + Hosp.</i>		e. CITY OR TOWN [If out of corporate limits, write RURAL and give nearest town] <i>Silver Spring</i>	
3. NAME OF DECEASED (Type or print) <i>Daniel Beard</i>		d. STREET ADDRESS <i>3106 Weller Rd. 34</i>	
First Middle Last		DATE OF DEATH <i>3 9 1961</i>	
5. SEX <i>m</i>		6. COLOR OR RACE <i>W</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>2-21-14</i>	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] <i>Route Sales - Milk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Thompson Dairy</i>	
11. BIRTHPLACE (State or foreign country) <i>W. Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph T. Pinnell</i>		14. MOTHER'S MAIDEN NAME <i>Lillie Copanhaver</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank and date of service) <i>No</i>		16. SOCIAL SECURITY NO <i>235-18-4325</i>	
17. INFORMANT <i>Mrs Mildred Pinnell - wife</i>		Address <i>Same Address</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>9/16</i> Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO DUE TO DUE TO		Cerebral hemorrhage and massive laceration Bullet wound of the head 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Reported to be self-inflicted bullet wound</i>		20c. TIME OF INJURY Month, Day, Year <i>8:55 a.m. 3-9 1961</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	
20f. (City or town) <i>Bethesda</i>		(County) <i>Montgomery</i>	
(State) <i>Md.</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Frank J. Broschart</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>TRANSIT & BURIAL</i>		DATE SIGNED <i>3-9-61</i>	
22b. DATE THEREOF <i>3/9/61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>METHODIST CEMETERY</i>	
22d. LOCATION (City, town, or country) <i>Alton, West Virginia</i>		(State) <i>West Virginia</i>	
23. FUNERAL DIRECTOR <i>Warren E. Pumphrey, Inc.</i>		24a. REC'D BY REGISTRAR <i>MAR 14 '61</i>	
ADDRESS <i>SILVER SPRING, MD.</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	
DATE <i>Raymond A. Gaska</i>			



1
FOR STATE
HEALTH DEPT.

M

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please secure the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be used for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-tranit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3341 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03329

1. PLACE OF DEATH
a. COUNTY

Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN lb

MARYLAND

28 min.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Washington Sanitarium and Hospital

First Middle

3. NAME OF
DECEASED
(Type or print)

Burt

6. COLOR OR RACE

male white

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Watertown, N.York N.S.A.

13. FATHER'S NAME

Edward Plumadore

14. MOTHER'S MAIDEN NAME

Florence Lowe

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If yes give rank or dates of service)

yes W.W.I

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

420.1 DUE TO

Conditions, if any, which

gave rise to immediate cause

(a), stating the underlying

cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS

FACTORY OR CONTRIBUTING

CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

20d. INJURY OCCURRED

While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion

death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE *Frank J. Boschart*

EXAMINER'S NAME (Type) *Frank J. Boschart*

22a. BURIAL / CREMATION 22b. DATE THEREOF

Moving to Wash. D.C.

burial 3/7/61

22c. NAME OF CEMETERY OR CREMATORIAL

Arlington Nat. Cem.

22d. LOCATION (City, town, or county)

Arlington, Virginia

(State)

23. FUNERAL DIRECTOR

Hed. N. Kline Co.

2801-4 100-210

Wash., D.C.

24a. REC'D BY REGISTRAR

MAR 7 '61

DATE

7. MAR 7 '61

REGISTRAR'S SIGNATURE

J. H. S. Kline

DATE

7. MAR 7 '61

REGISTRAR'S SIGNATURE

J. H. S. Kline

DATE

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REGISTRAR'S SIGNATURE

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REGISTRAR'S SIGNATURE

J. H. S. Kline

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J. H. S. Kline

DATE

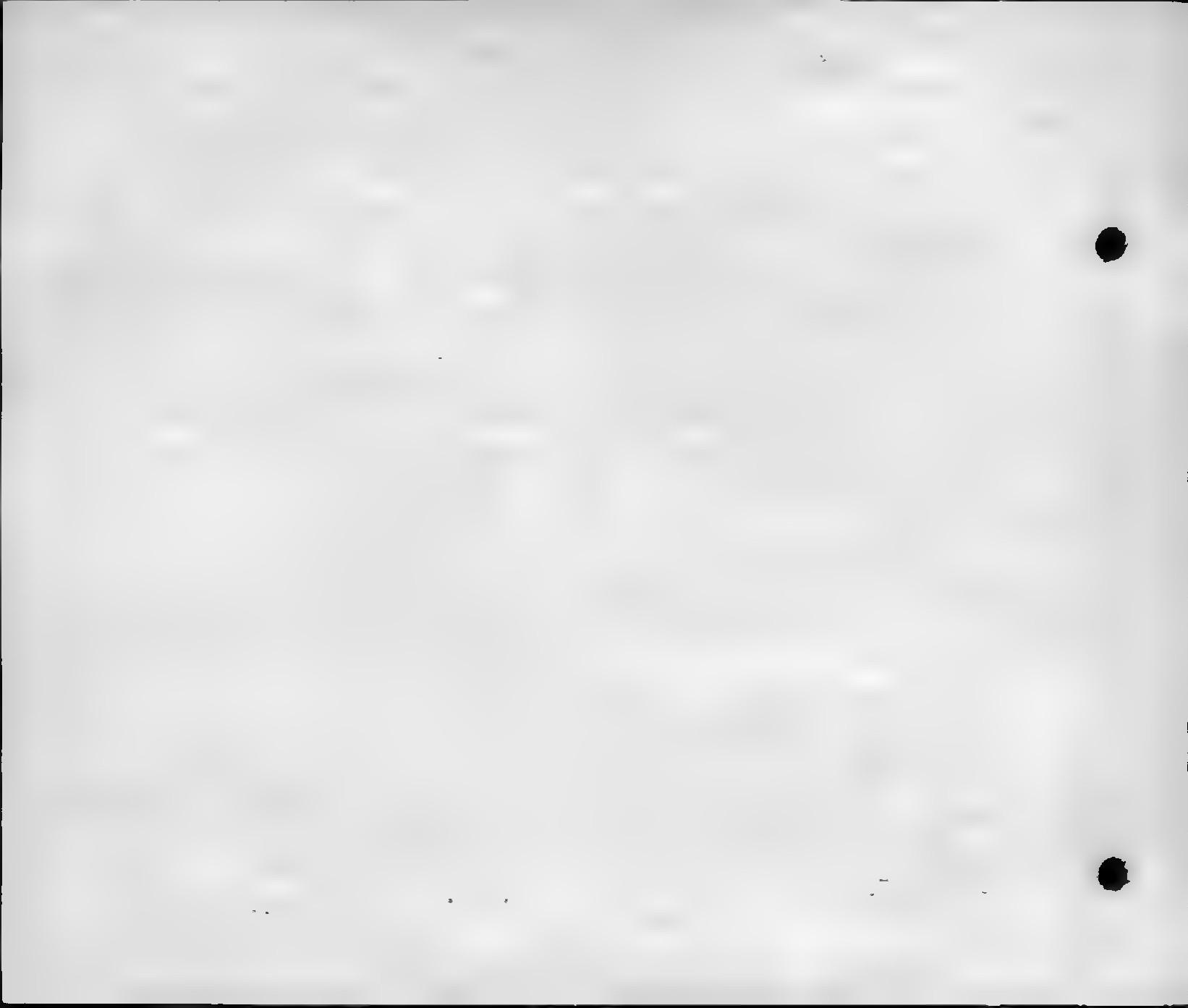
7. MAR 7 '61

REGISTRAR'S SIGNATURE

J. H. S. Kline

DATE

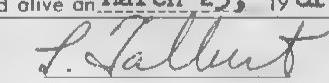
7. MAR 7 '61



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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3, which should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

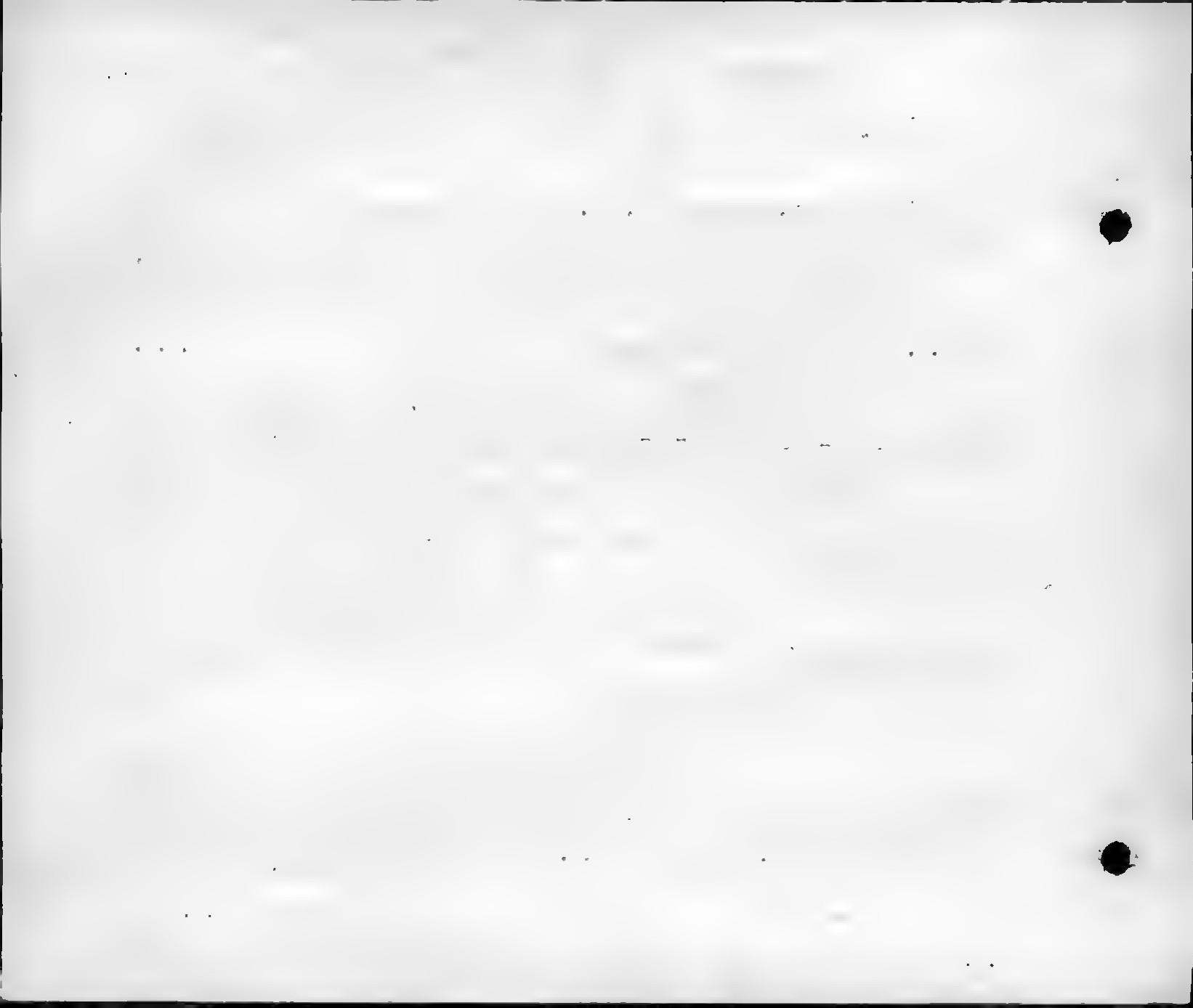
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission) STATE Massachusetts b. COUNTY									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				c. LENGTH OF STAY IN lb 18 days e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millbury d. STREET ADDRESS 12 Middleton Street									
3. NAME OF DECEASED (Type or print)		First Gladys	Middle Rosealene	Last Poasant	4. DATE OF DEATH Month March Day 23 Year 19 61								
S. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 26, 1917		9. AGE (In years last birthday) 43 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (State or foreign country) Massachusetts				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Stamper, Sr.						14. MOTHER'S MAIDEN NAME Elizabeth Williamson							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO 031-18-3176				17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Failure INTERVAL BETWEEN ONSET AND DEATH 3 yrs.													
(b) Mitral insufficiency 6 yrs. DUE TO													
(c) Rheumatic Heart disease, inactive 36 yrs. DUE TO													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) Was an autopsy performed? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c TIME OF INJURY Month Day Year Hour a. m. p. m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) March 5, 1961		20f (City or town) March 23, 1961		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from March 5, 1961 , to March 23, 1961 , that (I) (we) last saw the deceased alive on March 23, 1961 , and that death occurred at 2:00 p.m. from the causes and on the date stated above.													
22a. SIGNATURE 						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 3/24/61							
22c. PHYSICIAN'S NAME (Type): JAMES L. TALBERT, M.D.						22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland							
23a BURIAL CREMATION REMOVAL (Specify) Burial		23b DATE THEREOF 3/23/61		23c NAME OF CEMETERY OR CREMATORIAL Bethesda		23d LOCATION (City, town, or county) Bethesda				(State)			
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. 1400 Clarendon St. N.W.						25a. REC'D BY REGISTRAR DATE MAR 27 '61							
						25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3, to be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										CERTIFICATE OF DEATH		03331	
1. PLACE OF DEATH a. COUNTY		Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived — If institution, residence before admission)		b. STATE		Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Bethesda		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		Sykesville		Howard ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		The Clinical Center, Bethesda 14, Md.		138 Days		d. STREET ADDRESS		Underwood Road		P X-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
S. SEX		6 COLOR OR RACE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B DATE OF BIRTH	9 AGE (In years last birthday) 22 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.				
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	December 1, 1938									
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country)		12 CITIZEN OF WHAT COUNTRY?							
A/2c U.S. Airforce		Armed Forces		Virginia		U.S.A.							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME									
Fountain Quesenberry				Cornelia Hylton									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		The Medical Records Address							
Yes 1958 - 61		220-34-5832		The Clinical Center, Bethesda 14, Maryland									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Cerebrovascular accident						1 Hour					
204		DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)		Chronic Myelogenous leukemia						2 Years			
DUE TO		(c)											
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town)		(County)		(State)			
19													
21. I certify that (I) (this hospital) attended the deceased from October 24, 1960, to March 11, 1961, that (I) (we) last saw the deceased alive on March 11, 1961, and that death occurred at 2:25 P.M. on the causes and on the date stated above													
22a. SIGNATURE		Richard E. Rieselbach M.D.						22b. DATE SIGNED 3/12/61					
22c PHYSICIAN'S NAME (Type)		Richard E. Rieselbach M.D.						22d ADDRESS National Institutes Of Health The Clinical Center, Bethesda, Maryland					
23a BURIAL, CREMATON REMOVAL (Specify)		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORI		23d LOCATION (City, town, or county)		(State)					
Burial		3-16-60		Calvary		Portsmouth, N.H.							
24 FUNERAL DIRECTOR'S SIGNATURE		ADDRESS						25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
F.C. Higinbotham, Ellicott City, Md.								DATE MAR 15 '61		Clifton S. Kraus			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

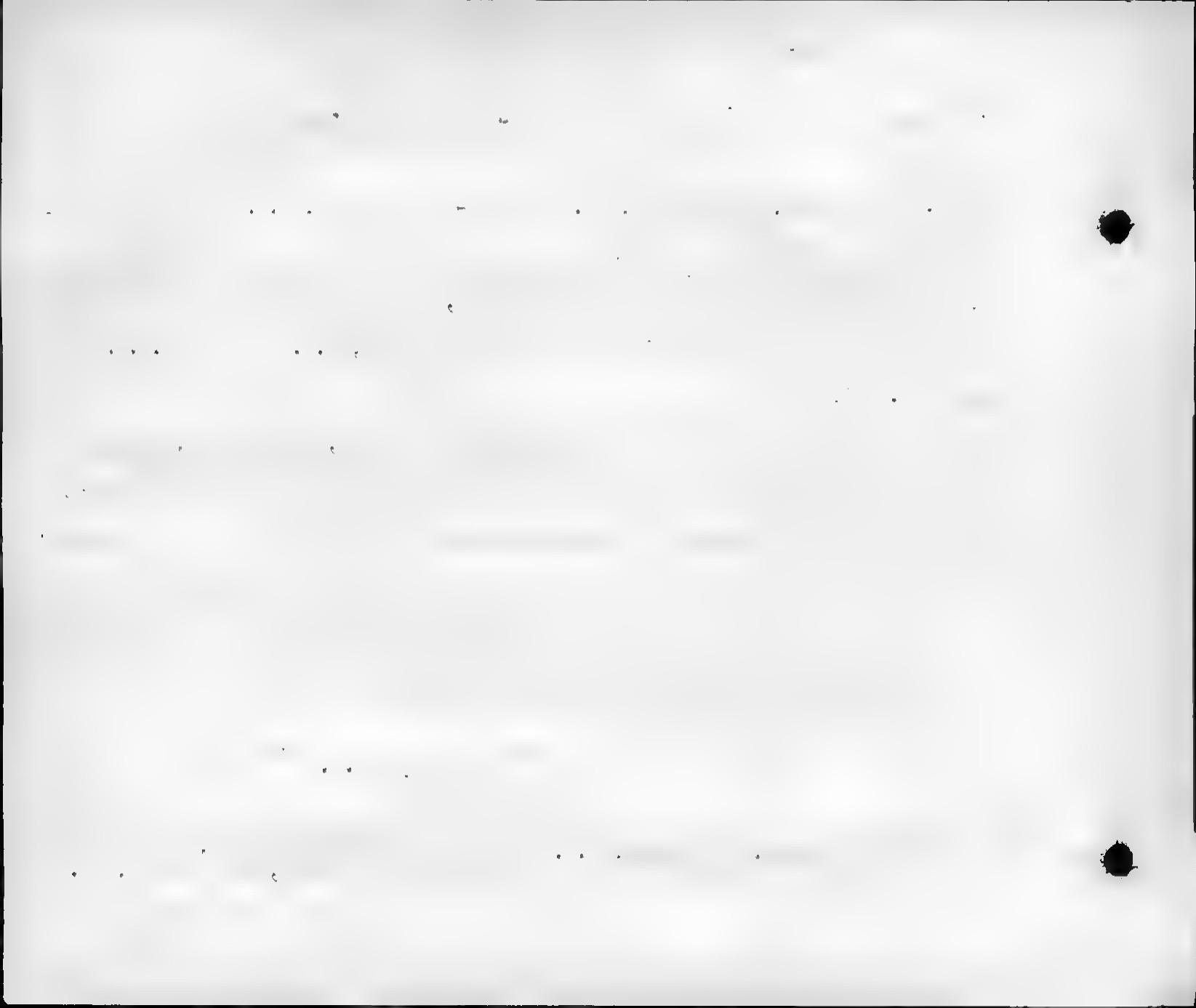
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03332

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 30 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 4964 - 12th Street, N.E.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Robert	Middle Emmett	Last Quirk	4. DATE OF DEATH March	Month March	Day 8	Year 1961
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH June 11, 1905	9. AGE (In years last birthday) 55	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS Hours 5	IF UNDER 24 HRS Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael J. Quirk				14. MOTHER'S MAIDEN NAME Lillie Mobley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of serv.) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia							
204 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. Acute Lymphocytic Leukemia							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). INTERVAL BETWEEN ONSET AND DEATH 2 Weeks							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from February 6 1961 to March 8 1961 , that (I) (we) last saw the deceased alive on March 8 1961 , and that death occurred at 3:40 P.M. from the causes and on the date stated above							
22a. SIGNATURE Richard E. Reiselbach		M.D.		ATTENDING PHYS <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>	22b. DATE SIGNED 3/8/61
22c. PHYSICIAN'S NAME (Type) RICHARD E. REISELbach, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL/CREMATION CREMATION		23b. DATE THEREOF 3-11-61		23c. NAME OF CEMETERY OR CREMATORIAL Fort Lincoln Cem.		23d. LOCATION (City, town, or county) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home 300-4th Street N.E.				ADDRESS		25a. REC'D BY REGISTRAR DATE MAR 10 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

M

3345

03333

CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)First
EmmaMiddle
JaneLast
Raines5. SEX
Female6. COLOR OR RACE
White7. MARRIED
WIDOWED XNEVER MARRIED
DIVORCED8. DATE OF BIRTH
Feb 28, 18774. DATE
OF
DEATH
March 19
1961Month
Daye. IS RESIDENCE
ON A FARM?
YES NO

Year

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)
Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Virginia

U.S.A.

13. FATHER'S NAME

Elijah Raines

14. MOTHER'S MAIDEN NAME

Fannie Ellen Shakelford

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Elton M. Raines

113 Elm Ave.; Takoma Pk, Md

INTERVAL BETWEEN
ONSET AND DEATH

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Cerebral Hemorrhage

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause first.

(b)

Aterosclerosis generalized

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, e)

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 1920d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)20f. City or town
(County) (State)21. I certify that (I) (this hospital) attended the deceased from ... 1 Nov 1957 to 17 Mar 1961, that (I) (we) last
saw the deceased alive on ... 17 Mar 1961, and that death occurred at 9:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Thomas P. Taggart

ATTENDING
PHYS.
M.D.
MED. DIRECTOR
22d. ADDRESSSTAFF
PHYS.
22b. DATE
SIGNED
17 Mar 6122c. PHYSICIAN'S
NAME (Type)23a. BURIAL, CREMATION, 23b. DATE THEREOF
REMOVAL (Specify)
Burial 3-22-61

23c. NAME OF CEMETERY OR CREMATORIUM

Cedar Hill Cemetery

23d. LOCATION (City, town or county)

Suitland, Maryland

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

Deal Funeral Home

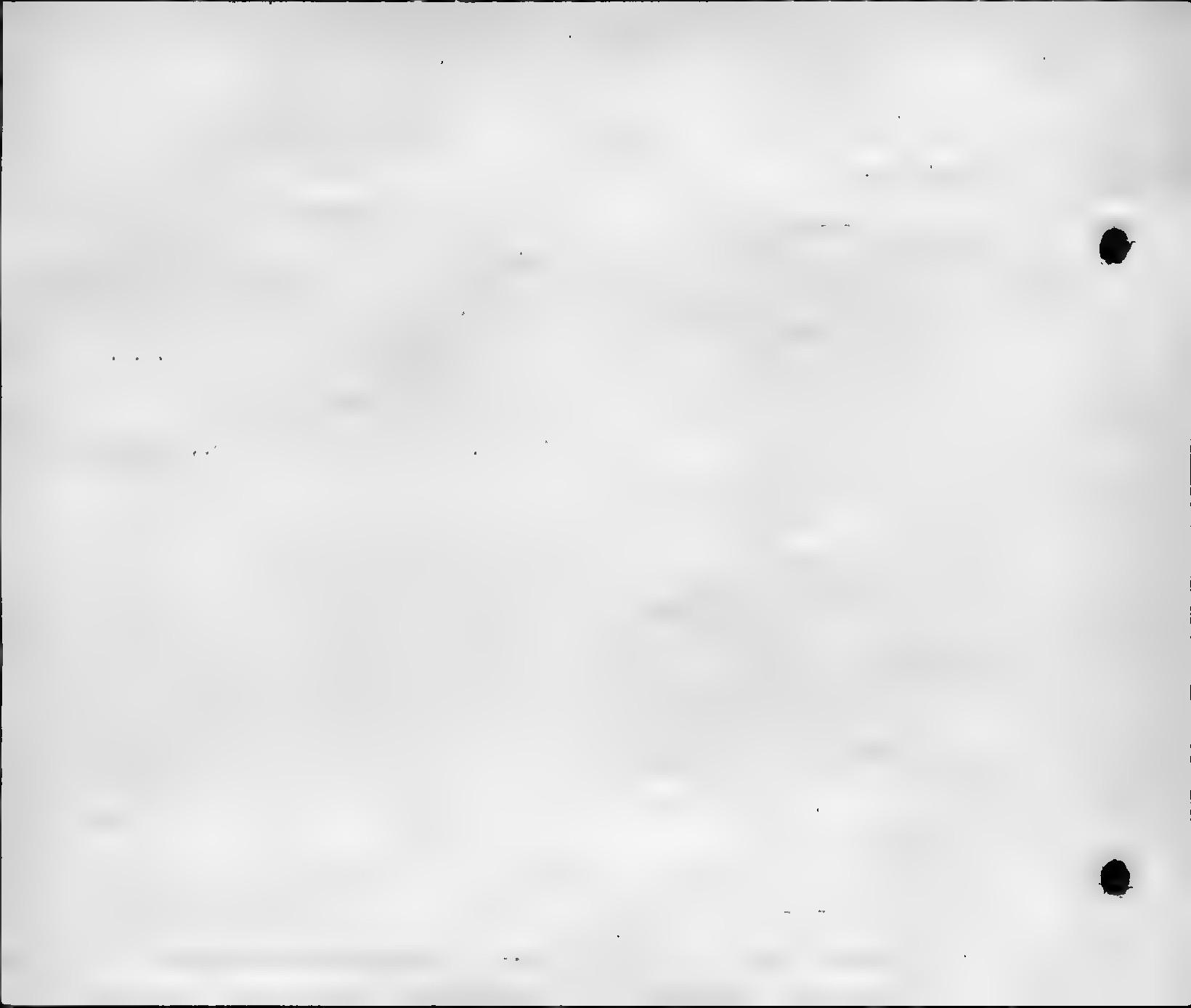
ADDRESS

4812 Georgia Ave., NW

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

MAR 22 '61

Charles S. Knott



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3346

CERTIFICATE OF DEATH

Reg. Dist. No. 113354

1. PLACE OF DEATH o COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville- Rural		c. LENGTH OF STAY IN lb 4 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Matthews Nursing Home		d. STREET ADDRESS -----		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Addie	Middle M.	Last Reddick	4. DATE OF DEATH	Month 3	Day 28	Year 19 61		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH May 29 1869	9. AGE (In years last birthday) 91 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John H. Spurrier		14. MOTHER'S MAIDEN NAME Martha Biggs		Address Poolesville, Md.					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		INFORMANT Claude Reddick		INTERVAL BETWEEN ONSET AND DEATH 48 hours			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY (IMMEDIATE CAUSE (a)) DUE TO Conditions, if any which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		Cerebrovascular Accident		Cerebral Arteriosclerosis		10 years			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 22 October, 19 61, to 28 March, 19 61, that I last saw the deceased alive on 27 March, 19 61, and that death occurred at 5 P.M. from the causes and on the date stated above ACTUAL SIGNATURE <i>Gordon M. Smith</i>		ADDRESS (Street, city or town, state) Barnesville, Md.						DATE SIGNED 29 March, 19 61	
PHYSICIAN'S NAME (Type) Gordon M. Smith		Barnesville, Md.							
22a BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 3/31/61		22c. NAME OF CEMETERY OR CREMATORIAL Monocacy		22d LOCATION (City, town, or county) Beallsville		(State) Md.	
23 FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton		ADDRESS Barnesville, Md.		24a. REC'D BY REGISTRAR APR 3 '61		24b. REGISTRAR'S SIGNATURE Walter S. Trahan			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VS A15 (4)
15M 9/58

errata

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3347

03335

CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

U.S. Naval Hospital

3. NAME OF DECEASED

(Type or print)

First

Middle

B.

Carroll

4. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

Male

Caucasian

WIDOWED

D VORCED

10e. **USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired)

Congressman

13. FATHER'S NAME

John I. REECE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? YES NO UNKNOWN (If yes, give rank or grade of service)

16. SOCIAL SECURITY NO. **17. INFORMANT**

17. INFORMANT

18. CAUSE OF DEATH [Enter only one cause of death for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

162-1

Bronchogenic carcinoma

INTERVAL BETWEEN
ONSET AND DEATH

3 months

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) **19. WAS AUTOPSY PERFORMED?**

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 1B)

20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While Not White
Hour a.m. p.m. 19 at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) ~~REED MILLER JR.~~ attended the deceased from March 9, 1961, to March 19, 1961, that (I) ~~REED~~ last saw the deceased alive on March 19, 1961, and that death occurred at 6:55 AM the causes and on the date stated above.

22a. S.ATURE *Russell Miller Jr. MD* M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. 22b. DATE SIGNED 3-19-61

22c. PHYSICIAN'S NAME (Type) **Russell MILLER Jr. LT, MC, USN** U.S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL (State)

Burial 3-20-61 Monte Vista, Johnson City, Tennessee

24 FUNERAL DIRECTOR'S SIGNATURE *Joseph Gowler's & Sons, Washington, D.C.* ADDRESS

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE MAR 21 '61 *Arthur S. Trahan*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

CERTIFICATE OF DEATH

3348

03336

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

Bethesda

c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Resmor Sanitarium & Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Julie

L.

Reynolds

5. SEX

female

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED
WIDOWED DIVORCED

8. DATE OF BIRTH

5/17/1883

4. DATE
OF
DEATH

March 16

9. AGE (in years
last birthday)

77 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Jacob Nilsson

Denmark

14. MOTHER'S MAIDEN NAME

Olene Hansen

U.S.A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT
(Yes, no, or unknown) (If yes, give war record date of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

N.W. Wash, D.C.

18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

46 X DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Probable Macereric Varul Thrombosis
Progressive Elatic Phlebitis Thrombosis 2nd deg
Esophagus, fund gall

INTERVAL BETWEEN
ONSET AND DEATH

today

3 wks.

MEDICAL CERTIFICATION

19. WAS AUTOPSY PERFORMED?
YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour 10 a.m.
p.m. 3/16/61

20d. INJURY OCCURRED While Not While
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg. etc.)
20f. (City or town) (County)

21. I certify that (I) (this hospital) attended the deceased from

saw the deceased alive on March 16 1961, and that death occurred at 11:15 A.M. from the causes and on the date stated above

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

23a. BURIAL OR CREMATION REMOVAL (Specify)

Removal 3/17/61

23b. DATE THEREOF

3/17/61

23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS

Lake View Cemetery Wash, D.C.

23d. LOCATION (City, town or county) (State)

Ithaca, N.Y. (State)

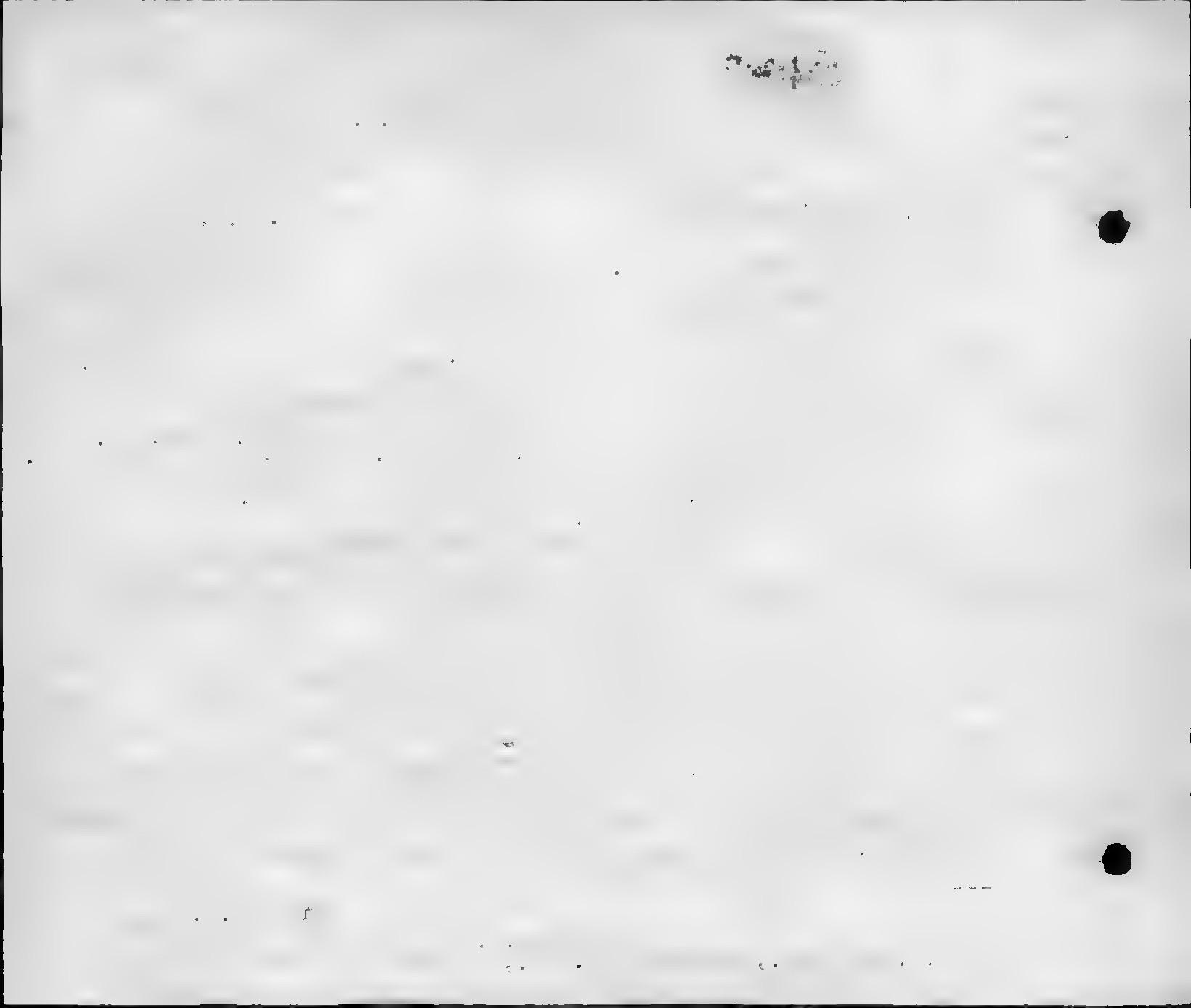
23e. REC'D BY REGISTRAR

Arthur S. Kline

24. FUNERAL DIRECTOR'S SIGNATURE

The S.H. Hines Co., 2901 14th St. N.W.,

DATE MAR 17 '61



may be signed by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with
 Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3349

CERTIFICATE OF DEATH

03337

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Virginia</i>		b. COUNTY <i>Warren</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>19 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Front Royal</i>		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Congressional manor Sanitarium</i>								e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First <i>Minnie</i>	Middle <i>E</i>	Lost <i>Ridgeway</i>	4. DATE OF DEATH Month <i>3</i>	Month <i>10</i>	Day <i>1961</i>	Year	
S SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	b. DATE OF BIRTH <i>12/20/1874</i>	9. AGE (In years at birthday) <i>86 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.			
10a. US-JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Clerk, warden</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Ortha G Ridgeway</i>		14. MOTHER'S MAREN NAME <i>Sarah Brown</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>33</i> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <i>Recent amputation of rt. thigh-Dry gangrene of left foot due to arteriosclerosis of veterans.</i>								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter place of injury in Part 1 or Part II) <i>18</i> <i>20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19</i> 20d. INJURY OCCURRED <i>White Not white of work <input type="checkbox"/> at work <input type="checkbox"/></i> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)								
21. I certify that (I) (this Hospital) attended the deceased from <i>January 9, 1961</i> to <i>March 10, 1961</i> , that (I) (we) last saw the deceased alive on <i>March 9, 1961</i> , and that death occurred at <i>9:30 A.M.</i> from the causes and on the date stated above 22. SIGNATURE <i>George A. Gray, Jr.</i>								
22d. DATE <i>March 10, 1961.</i>								
22c. PHYSICIAN'S NAME (Type) <i>George A. GRAY, JR. M.D.</i>		M.D. ATTENDING PHYS		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				
22d. ADDRESS <i>4140 Chevy Chase, D.C. Chevy Chase, MD</i>								
23a. BURIAL, CREMATION REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>3-12-61</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>FREDERICK BUR. GRD.</i>		23d. LOCATION (City, town, or county) <i>WARREN COUNTY VA.</i>		
24. FUNERAL DIRECTOR'S SIGNATURE <i>MADDUX FUNERAL HOME C.R. Maddux, Jr.</i>		ADDRESS <i>FRONT ROYAL, VA.</i>		25a. REC'D BY REGISTRAR <i>Arthur S. Evans</i>		25b. REGISTRAR'S SIGNATURE		
				DATE <i>MAR 14 '61</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

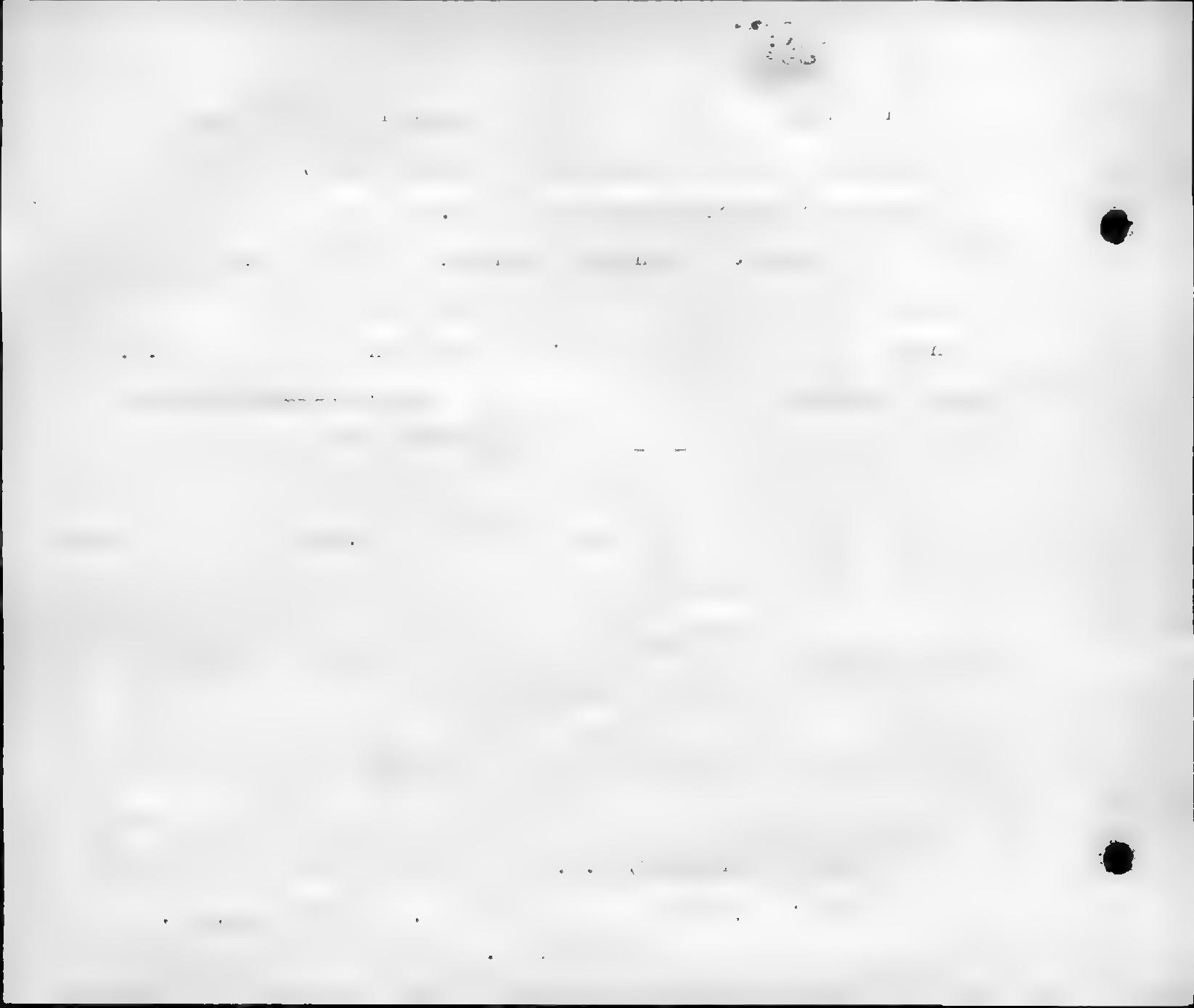
may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
Page 3, to be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03338

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b (1)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		d. STREET ADDRESS Rt. 2			
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) Montgomery General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Wilbur Stansbury Rinehart		First	Middle	Last	4. DATE OF DEATH March 30 1961	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1/19/02	9. AGE (in years last birthday) 59 yrs	10. IF UNDER 1 YEAR Months 59	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. CITIZEN OF WHAT COUNTRY? U.S.A.
10a. USUA. OCCUPAT. ON (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY School Buildings		11. BIRTHPLACE (State or foreign country) Maryland					
13. FATHER'S NAME Lewis Rinehart				14. MOTHER'S MAIDEN NAME Antonia Ritchie Scheckels					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-01-6794		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS INTERVAL BETWEEN ONSET AND DEATH 10 hours 420.1 DUE TO Conditions if any, which gave rise to immediate cause (a) stating the under- lying cause last (b) Prietary Parkinsonism 15 years DUE TO (c) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE 15 years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) OLD CEREBRAL THROMBOSIS									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Kirkville, Maryland		(County) Montgomery	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from 2011 , 19 58 , to March 30 1961 , that (I) (we) last saw the deceased alive on MARCH 29 1961 , and that death occurred at 8:00 AM , from the causes and on the date stated above.									
22a. SIGNATURE Gordon Rosenberger		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED March 30, 1961					
22c. PHYSICIAN'S NAME (Type) Gordon Rosenberger, M.D.		22d. ADDRESS Kirkville, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 1, 1961		23c. NAME OF CEMETERY OR CREMATORIUM Damascus Meth.		23d. LOCATION (City, town, or County) Damascus, Md.		(State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Olin L. Mobsunth		ADDRESS Damascus, Md.		25a. REC'D BY REGISTRAR 4/4 '61		25b. REGISTRAR'S SIGNATURE Civilla S. Kraus			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3351

CERTIFICATE OF DEATH

Reg. Dist. No. 03339

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>D.C.</i>		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN lb <i>1b</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>		d. STREET ADDRESS <i>2025 Lawrence St. N.E.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cedars of Lebanon Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>Eula</i>	Middle <i>Elizabeth</i>	Last <i>Robey</i>	4. DATE OF DEATH <i>March 28 1961</i>	Month <i>March</i>	Day <i>28</i>	Year <i>1961</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <i>Dec. 15 1888</i>	9. AGE (In years last birthday) <i>72 yrs.</i>	10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months <i>0</i>	Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Worked for Bureau of Engraving</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Pomfret Maryland</i>		11. BIRTHPLACE (State or foreign country) <i>Pomfret Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Henry T. Robey</i>		14. MOTHER'S MAIDEN NAME <i>Lizzie MARTIN</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Address</i>		17. INFORMANT <i>J-R-Y-N-C. Robey - #2d.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a)-(b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.</i>		DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</i>		C. CONGESTIVE HEART FAILURE		INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs.</i>			
(b) DUE TO <i>Arteriosclerotic heart disease</i>		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>ADDRESS (Street, city or town, state)</i>							
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <i>M.D. 1429 University Blvd. W. Silver Spr.</i>		20f. (City or town) <i>SUITLAND, MD.</i>		(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from <i>December 1952</i> to <i>3-28-1961</i> , that I last saw the deceased alive on <i>3-28-1961</i> , and that death occurred at <i>9:15 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Aldo Vacca</i>		ADDRESS (Street, city or town, state) <i>DATE SIGNED</i> <i>3-28-1961</i>							
PHYSICIAN'S NAME (Type) <i>Aldo VACCA</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>3-30-61</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>CEDAR HILL</i>		22d. LOCATION (City, town, or county) <i>SUITLAND, MD.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>JAMES T. RYAN INC.</i>		ADDRESS <i>817 Pa. Ave. S.E.</i>		24a. REC'D BY REGISTRAR <i>DATE MAR 30 '61</i>		24b. REGISTRAR'S SIGNATURE <i>ALICE</i>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3352

CERTIFICATE OF DEATH

03340

1. PLACE OF DEATH
a. COUNTY

MONTGOMERY

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

TAKOMA PARK 8 MO.

c. LENGTH OF STAY IN TB

d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp tel, give street address)

7520 - MAPLE AVE.

3. NAME OF
DECEASED
(Type or print)First
JuliaMiddle
M.Last
Rooney4. DATE
OF
DEATH
Month
March
Year
1961

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. MARRIED
WIDOWEDNEVER MARRIED
DIVORCED

8. DATE OF BIRTH

7-24-75

9. AGE (in years
last birthday)

85 yrs.

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

At Home

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

MASS.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

MICHAEL PITTS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give rank, dates of serv.)

No

16. SOCIA. SECURITY NO.

17. INFORMANT

Address

TULIA MARY WHITE

DOROTHY DOWD. SAME AS #1.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Terminal pneumonia

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b) Cerebral vascular hemorrhage.

DUE TO

(c) Advanced Arthritis.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY
Hour a.m.
p.m.20d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from... Aug. 1961 to ... March 7, 1961, that (I) (we) last
saw the deceased alive on... March 23, 1961, and that death occurred at..... M, from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.

22d. ADDRESS

22e. SIGNATURE

22b. DATE
SIGNED

Robert B. Frey 7105 Riggs Rd. Hyattsville Md.

Burial 3-27-61 Mt Olivet Cemetery Washington D.C.

Francis J. Collins 3821-14th N.W. Wash. D.C. MAR 27 '61

Address 8th Street



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

113341

3353

CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

U. S. Naval Hospital,

3. NAME OF
DECEASED
(Type or print)

First

Middle

Harold

Eugene

5. SEX

16 COLOR OR RACE

7. MARRIED NEVER MARRIED

b. DATE OF BIRTH

Male Caucasian WIDOWED DIVORCED

ROWCLIFF

4-26-35

4. DATE
OF
DEATH

Month

Day

Year

March

16

19 61

9 AGE (in years) IF UNDER 1 YEAR
last birthday Months Days Hours Min.

25 yrs

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Armed Forces

U.S. Marine Corps

Illinois

13. FATHER'S NAME

Cyril A. ROWCLIFF

14. MOTHER'S MAIDEN NAME

Hazel V. BULL

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT
(Yes, no, or unknown) (If yes, give rank or date of service)

Yes

1953 to DOD

334-26-2833 | Hospital Records

INTERVAL BETWEEN
ONSET AND DEATH
5 weeks

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

lymphosarcoma, generalized

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (this hospital) attended the deceased from **March 12, 1961** to **March 16, 1961**, that (we) last
saw the deceased alive on **March 16, 1961**, and that death occurred at **5:00PM** from the causes and on the date stated above.

22a. SIGNATURE

Paul G. Linaweafer

M.D. ATTENDING PHYS.
MED. DIRECTOR STAFF PHYS.
22d. ADDRESS

22b. DATE
SIGNED
3-17-61

22c. PHYSICIAN'S
NAME (Type)
Paul G. LINAWEAVER, LT, MC, USN U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION
REMOVAL (Specify)
Burial-Shipment

23b. DATE THEREOF
3-18-61

23c. NAME OF CEMETERY OR CREMATORIUM
Melvin Cemetery

23d. LOCATION (City, town or county)
Melvin

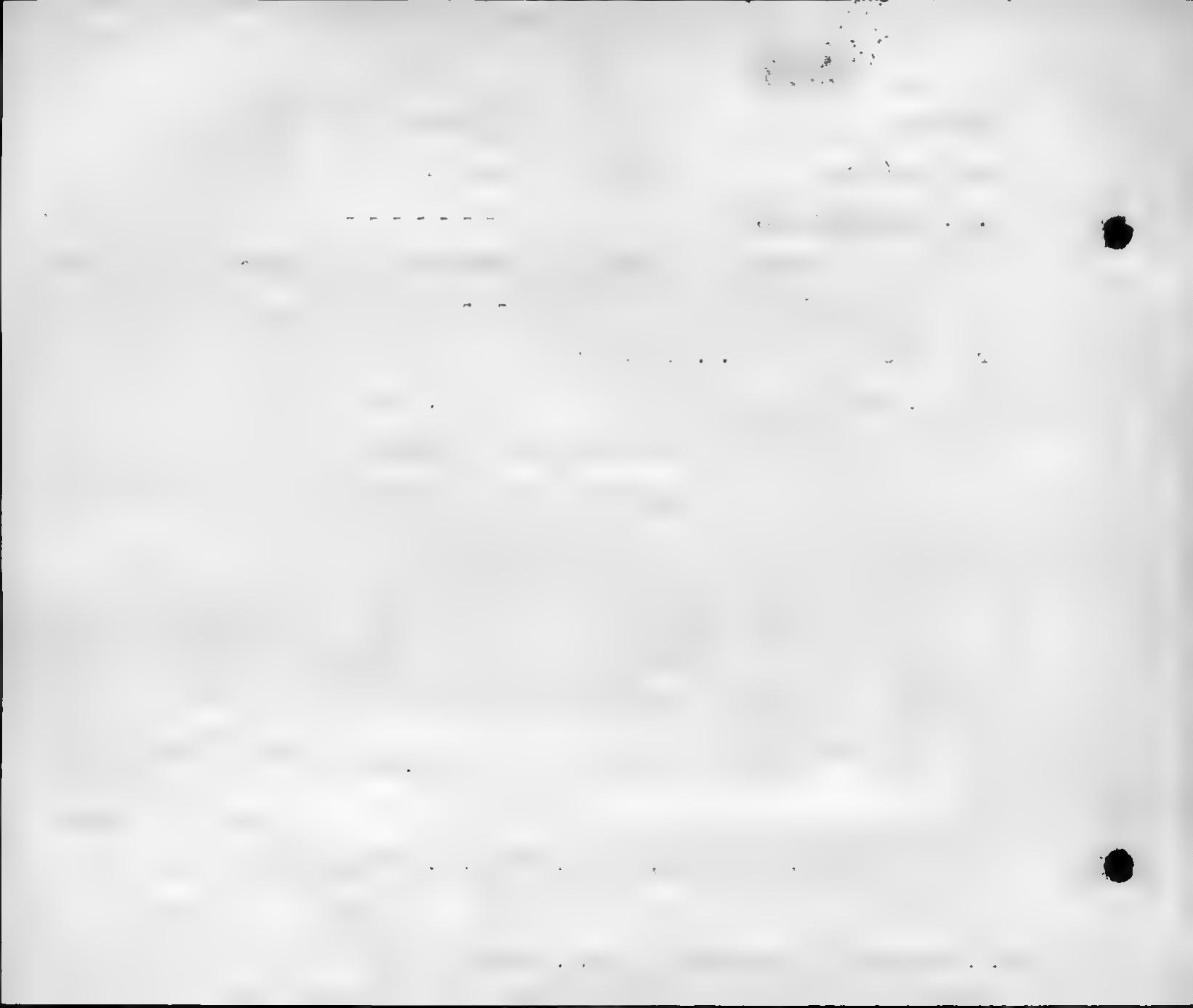
(State)

24. FUNERAL DIRECTOR'S SIGNATURE
W.W. Chambers Co.

1400 Chapin St., N.W., WashDC

25a. REC'D BY REGISTRAR
MAR 21 '61

25b. REGISTRAR'S SIGNATURE
John S. Kline



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3354

CERTIFICATE OF DEATH

113342

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN 1b

2 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Washington Sanitarium Hospital

3. NAME OF DECEASED
(Type or print)

First Thomas

Middle Joseph

Last Ryder

4. DATE OF DEATH

Month 3

Day 14

Year 1961

5. SEX

6. COLOR OR RACE

M

W

MARRIED NEVER MARRIED WIDOWED DIVORCED

7. DATE OF BIRTH

1-23-1900

9. AGE (In years last birthday)

61 yrs.

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done)
(if by day, state if working full or part time even if retired)

Supervisor

10b. KIND OF BUSINESS OR INDUSTRY

Western Union

11. BIRTHPLACE (State or foreign country)

District of Columbia Amer.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John F. Ryder

14. MOTHER'S MAIDEN NAME

Macy. Bassey

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO

579-07-6451

17. INFORMANT

Hospital Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a)

Brain Tumor (malignant)

INTERVAL BETWEEN
ONSET AND DEATH

7

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I(a). 19. WAS AN AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day Year
Hour a. m. 19 p. m.20d. INJURY OCCURRED
While at work Not while at work 20e. PLACE OF INJURY (Home, farm
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-15-1960 to 3-14-1961, that (I) (we) last saw the deceased alive on 3-13-1961, and that death occurred at 1 PM, from the causes and on the date stated above

22a. SIGNATURE

J. Marion Bankhead

M.D.

ATTENDING
PHYSMED
DIRECTORSTAFF
PHYS22b. DATE
SIGNED

3/14/61

22c. PHYSICIAN'S
NAME (Type)

J. Marion Bankhead

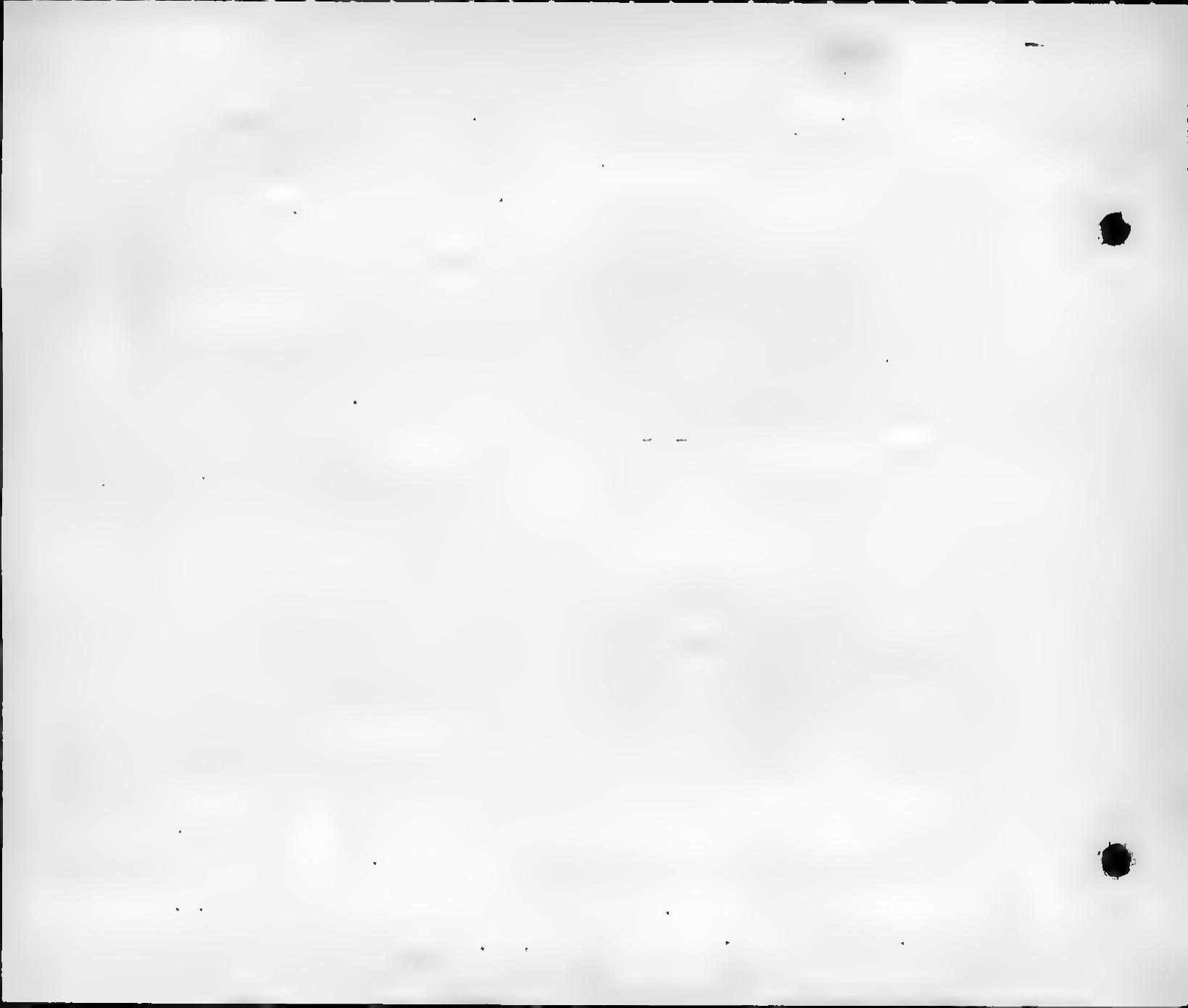
22d. ADDRESS

9241 Col. Blvd.
Silver Spring, Md.23a. BURIAL CREMATION
REMOVAL (Specify)
BURIAL23b. DATE THEREOF
3/17/6123c. NAME OF CEMETERY OR CREMATORIUM
MT. OLIVET CEMETERY23d. LOCATION (City, town, or county)
WASHINGTON, D.C. (State)

24. FUNERAL DIRECTOR'S SIGNATURE

RAYMOND J. FISKA, INC.

ADDRESS
SILVER SPRING, MD.25a. REC'D BY REGISTRAR
DATE MAR 20 '6125b. REGISTRAR'S SIGNATURE
Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3355

03343

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

MARYLAND

c. LENGTH OF STAY IN 1b

6 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Suburban Hospital

3. NAME OF
DECEASED
(Type or print)

First: Beatrice Middle: H.

5. SEX

6. COLOR OR RACE

W

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

April 27, 1888

9. AGE (In years last birthday)

72 yrs.

10. ADDRESS

5913 Johnson Ave

Month: March Day: 13 Year: 19 61

13. FATHER'S NAME

Sidney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give date of service)

No

16. SOCIAL SECURITY NO.

Boyle

17. INFORMANT

Yes

Unknown

Unknown

Address

Same as above

Mr. Merrill Vaughn (Son in Law)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY.
(IMMEDIATE CAUSE (a))

442X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

b)

DUE TO

c)

Anterior circumscribed Glomero-
vascular - General - General Nervous.
Unknown death cause - Pulmonary edema.INTERVAL BETWEEN
ONSET AND DEATH

3 Days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. TIME OF INJURY Month, Day, Year

Hour a.m.

Month

p.m.

Day

Year

20b. INJURY OCCURRED While at work Not While at work

20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

20d. (City or town)

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (his/hospital) attended the deceased from

22a. SIGNATURE

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIAL

ADDRESS

23d. LOCATION (City, town or county)

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

25a. REC'D BY REGISTRAR

DATE

25b. REGISTRAR'S SIGNATURE

26. ADDRESS

27. DATE

28. ADDRESS

29. DATE

30. ADDRESS

31. DATE

32. ADDRESS

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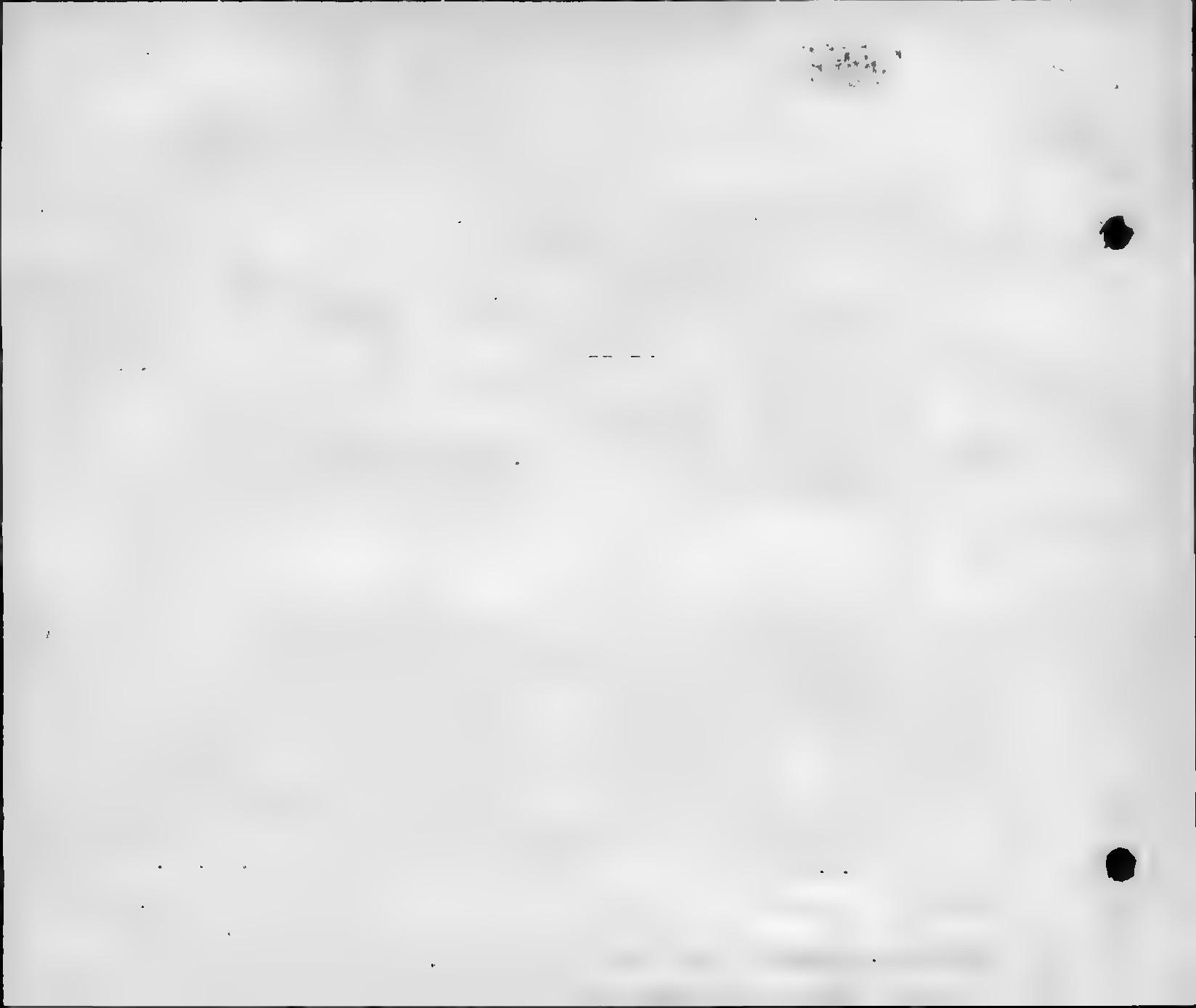
258. ADDRESS

259. DATE

260. ADDRESS

261. DATE

262. ADDRESS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 1SM 9/59

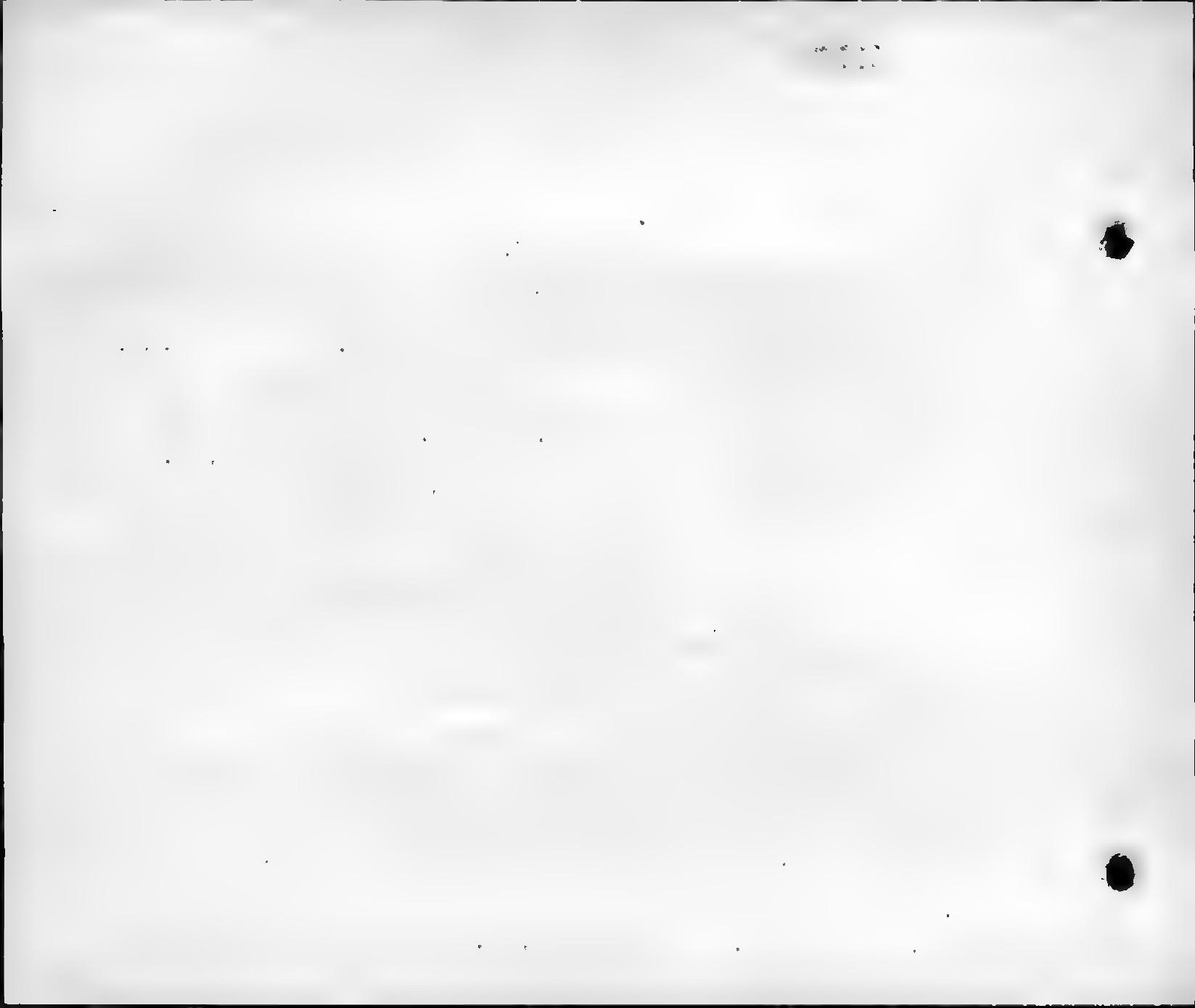
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3356

CERTIFICATE OF DEATH

03344

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FOREST GLEN</u>		c. LENGTH OF STAY IN 1b <u>16</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LeDeau Nursing Home</u>			d. STREET ADDRESS <u>3217 Fayette Road</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <u>ANNA</u>	Middle <u>DORA</u>	Last <u>SAGE</u>	4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1961</u>
S. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/6/77</u>		9. AGE (in years last birthday) <u>83</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Chicago, Ill.</u>	
13. FATHER'S NAME <u>CHARLES GUNTHER</u>			14. MOTHER'S MAIDEN NAME <u>ROSALIE</u> unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT Address <u>Mrs. Delmar W. Sage, 3217 Fayette Road Kensington, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Diverticulitis, Severe</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 hours</u>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>8X</u> <u>Stasis, Colon</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Left hemiplegia, old, stable</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>J nu rv 19 52 Mar 25 19 61, thot (I) (we) lost</u>			
20c. TIME OF INJURY Month, Day Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>16069 Concord St., Kensington, Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 24 19 61</u> and saw the deceased alive on <u>Mar 24 19 61</u> , and that death occurred on <u>Mar 25 19 61</u> from the causes and on the date stated above.		20f. (City or town) (County) (State)			
22a. SIGNATURE <u>John T. Thibdeau, M.D.</u>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>Mar 25 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>John T. Thibdeau, M.D.</u>		22d. ADDRESS <u>16069 Concord St., Kensington, Md.</u>			
23a. BURIAL, CREMATION OR REMOVAL (Specify) TRANS. & BURIAL <u>3/26/61</u>		23b. DATE THEREOF <u>3/26/61</u>		23c. NAME OF CEMETERY OR CREMATORIAL FACILITY <u>MEMORIAL PARK</u>	
23d. LOCATION (City, town, or county) <u>EVANSTON, ILLINOIS</u>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond J. Thibdeau</u>		ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 29 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>John S. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

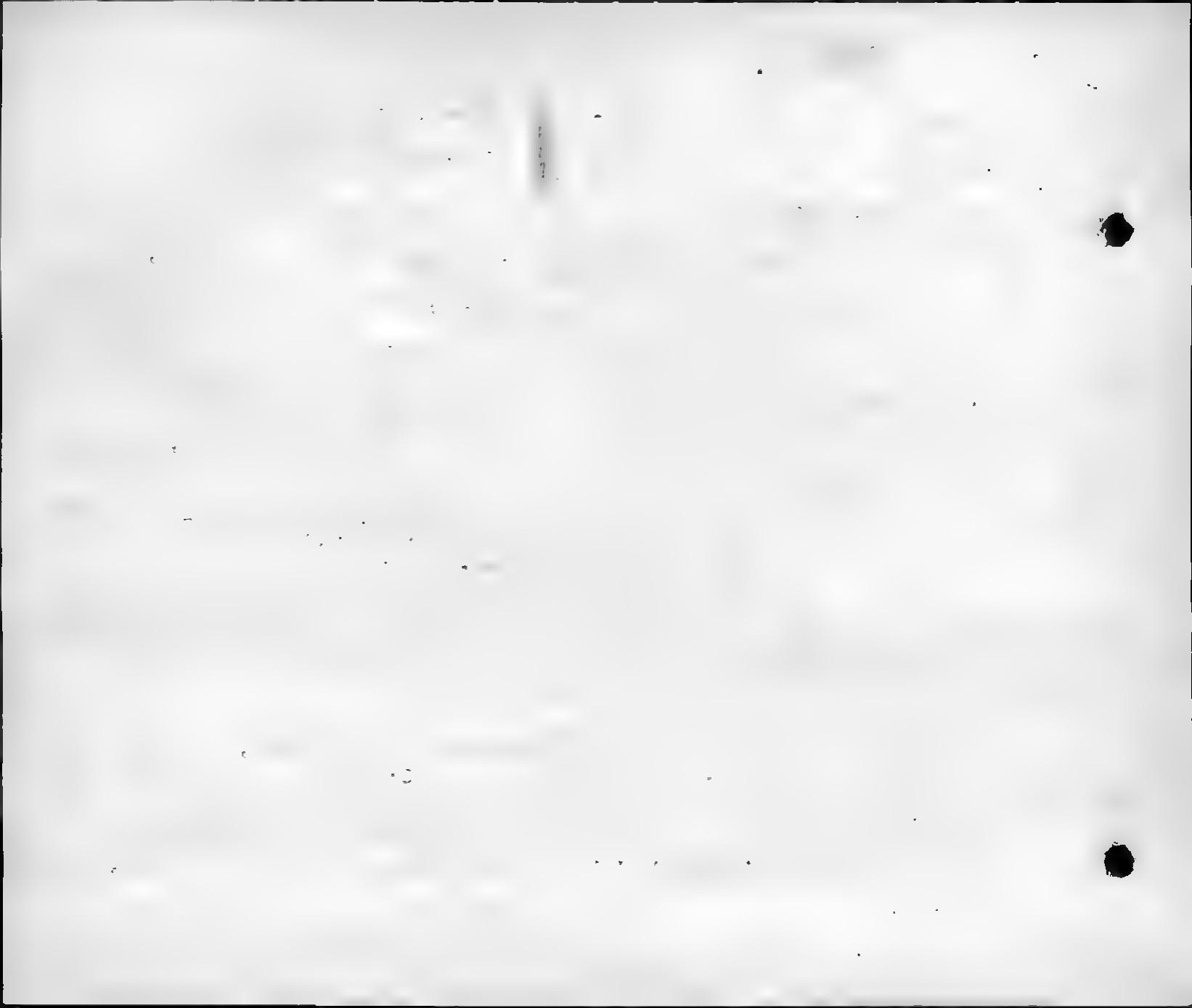
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3357

03345

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Kentucky		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 12 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hazard		d. STREET ADDRESS General Delivery		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Teresa		First	Middle (None)	Last Sampsell	4. DATE OF DEATH March 7, 1961	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 8, 1960		9. AGE (In years lost birthday) yrs 6 22	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS Days 22	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Roger Sampsell			14. MOTHER'S MAIDEN NAME Ruby Collins					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO Cyanotic congenital heart disease, Complete transposition of the great vessels; ventricular septal defect; patent ductus arteriosus (c)								
INTERVAL BETWEEN ONSET AND DEATH 6 months 22 days								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from February 23, 1961 , to March 7, 1961 . That (I) (we) last saw the deceased alive on March 7, 1961 . And that death occurred at 10:55 AM on the causes and on the date stated above.								
22a. SIGNATURE <i>Benson R. Wilcox, M.D.</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. 3/7/61		22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) Benson R. Wilcox, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland						
23a. BUR. A. CREMATION, REMOVAL (Specify) Burial-transit		23b. DATE THEREOF 3-8-61		23c. NAME OF CEMETERY OR CREMATORIAL Nable Cemetery		23d. LOCATION (City, town, or county) Hazard, Kentucky		
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.		25a. REC'D. BY REGISTRAR DATE MAR 10 '61		25b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3358

CERTIFICATE OF DEATH

03346

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

1. PLACE OF DEATH MONTGOMERY
B. COUNTY

9603 BRISTOL AVENUE MARYLAND

b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town)

SILVER SPRING SIX YEARS

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

9603 Bristol Avenue

3. NAME OF
DECEASED
(Type or print)

First

Middle

LYDIA JANE SAPHOS

5. SEX

6. COLOR OR RACE

FEMALE WHITE

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

SEPT. 16, 1890.

Last

4. DATE OF DEATH Month Dev Year

70 yrs.

6

6

1961

9. AGE (in years last birthday) IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY

OWN HOME

11. BIRTHPLACE (County & State or foreign country)

CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

REAMER H. ALSIP

14. MOTHER'S MAIDEN NAME

LOTTIG

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give rank or dates of service

NO

16. SOCIAL SECURITY NO. | 17. INFORMANT

578-03-9608 MR. STEPHEN SAPHOS

9603 Bristol Ave., Silver Spring

INTERVAL BETWEEN
ONSET AND DEATH
7 months

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Conditions, if any, which
gave rise to immediate cause } (b)
(a), stating the underlying }
cause first }
c.)

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from JUNE 15, 1960 to March 22, 1961 that (I) (we) last saw the deceased alive on March 22, 1961, and that death occurred at 9:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE *Charles John Demas Jr.*

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.
22b. DATE SIGNED 3-22-61

22c. PHYSICIAN'S NAME (Type) CHARLES JOHN DEMAS 1301 - Mass. Ave - Wash. 5 - D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIUM

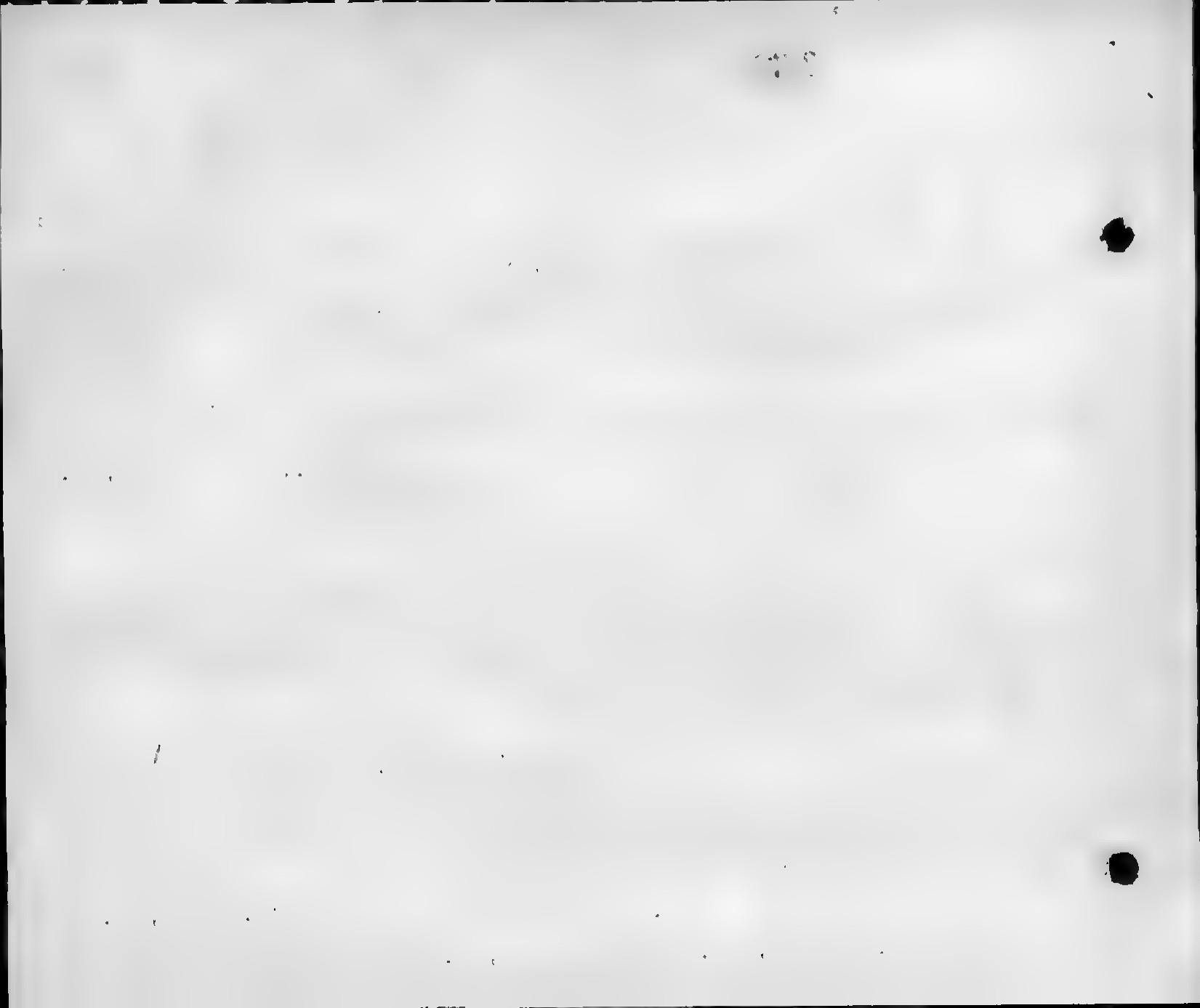
BURIAL 3/24/61 FT. LINCOLN CEMETERY

23d. LOCATION (City, town or county) (State)

PRINCE GEO. COUNTY, MD.

24. FUNERAL DIRECTOR'S SIGNATURE *Raymond E. Pupinsky Inc.* ADDRESS SILVER SPRING, MD.

25a. REC'D BY REGISTRAR MAR 27 '61 25b. REGISTRAR'S SIGNATURE *Arthur S. Kraus*



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached from page 3 and filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3359

CERTIFICATE OF DEATH

03347

PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town)

Bethesda (Rural)

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

U. S. Naval Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

David

Griffith

2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)

a. STATE

Virginia

b. COUNTY

Arlington

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?

YES NO

c. LENGTH OF STAY IN b

25 days

5104 7th Street
Last Month Day Year

Schell

March

26 19 61

11-20-07

53

**IF UNDER 1 YEAR
Months Days Hours Min.**

53 yrs

**IF UNDER 24 HRS.
Hours Min.**

12. CITIZEN OF WHAT COUNTRY?

USA

3. SEX

6. COLOR OR RACE

Male

Caucasian

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Officer

10b. KIND OF BUSINESS OR INDUSTRY

U. S. Navy

11. BIRTHPL.A.E (County & State, or foreign country)

Pennsylvania

14. MOTHER'S MAIDEN NAME

Mary Jenkins

Address

Lois

Schell (W)

INTERVAL BETWEEN
ONSET AND DEATH

1 Year

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If yes give rank and date of service)

yes

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Adx 120 Cerebral

(V) / 1961 / 10 / 1961 / 10 / 1961

10179

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING

OR CONTRIBUTING

CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.

p.m.

19

2Dd. INJURY OCCURRED
While at work Not While at work

2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. (City or town)

(County)

(State)

21. I certify that **(b)** (this hospital) attended the deceased from **March 1, 1961**, to **March 26, 1961**, that **(b)** (we) last saw the deceased alive on **March 26, 1961**, and that death occurred at **0353AM** from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

J. L. BEEBY LT MC, USN

22b. DATE
SIGNED

3-26-61

22d. ADDRESS

U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

3-29-61

23c. NAME OF CEMETERY OR CREMATORI

Arlington National Cemetery

23d. LOCATION (City, town or county)

Arlington, Virginia

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

R. B. Chambers

W. W. CHAMBERS CO.,

1400 Chapin St., N.W. Wash. D.C.

ADDRESS

25a. REC'D BY REGISTRAR

MAR 28 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

• E. V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3360

CERTIFICATE OF DEATH

43343

1
1. PLACE OF DEATH
a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN 1b

3½ days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Suburban Hospital

3. NAME OF
DECEASED
(Type or print)

First Middle Last

Frederick

W.

Schneider

4. SEX

6. COLOR OR RACE

Male

White

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY

Sales Manager

11. BIRTHPLACE (County & State, or foreign country)

Washington, D.C.

13. FATHER'S NAME

John F. Schneider
John F. Schneider
(Yes, no, or unknown) (If yes give war records of service)

No

16. SOCIAL SECURITY NO. 17. INFORMANT

Caroline Imhof

4868 Chevy Chase Blvd.

18. CAUSE OF DEATH (Enter only one cause of death for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)IMMEDIATE CAUSE (a)
Due to
0-1Conditions, if any, which
gave rise to immediate cause
(e.g., stating the underlying
cause last.)

(b)

Due to

INTERVAL BETWEEN
ONSET AND DEATH

5 days

Myocardial Infarction, severe

Coronary sclerosis

Arteriosclerosis, generalised 10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Essential Hypertension

10 yrs

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year
Hour a.m. While Not While
p.m. at work at work 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.) 20f. (City or town)
(County) (State)21. I certify that (I) (this hospital) attended the deceased from 1950 to 3.28.1961, that (I) (we) last
saw the deceased alive on 3.27.1961, and that death occurred after 12 P.M. from the causes and on the date stated above.

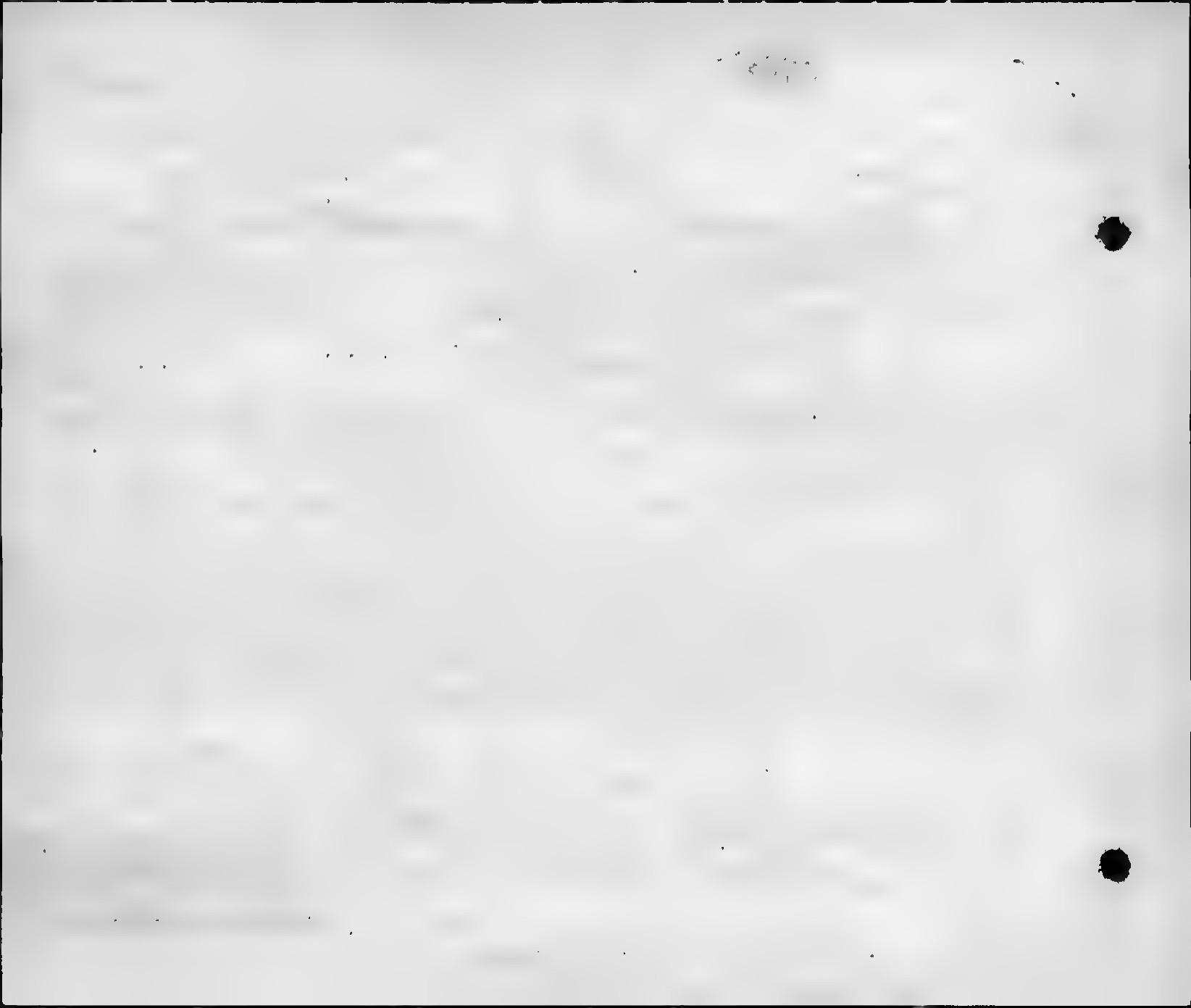
22a. SIGNATURE

Stewart Clapp M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.
22b. DATE SIGNED 3.28.61

22c. PHYSICIAN'S NAME (Type)

Stewart Clapp 4740 Ch. Ch. Dr. Chevy Chase Md.

23e. BURIAL, CREMATION, DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS 23d. LOCATION (City, town or county)
REMOVAL (Specify) PROSPECT HILL CEMETERY WASHINGTON, D. C.
Burial 3/31/61 Bethesda, Maryland24 FUNERAL DIRECTOR'S SIGNATURE 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey ADDRESS DATE 3/31/61 7.2.61



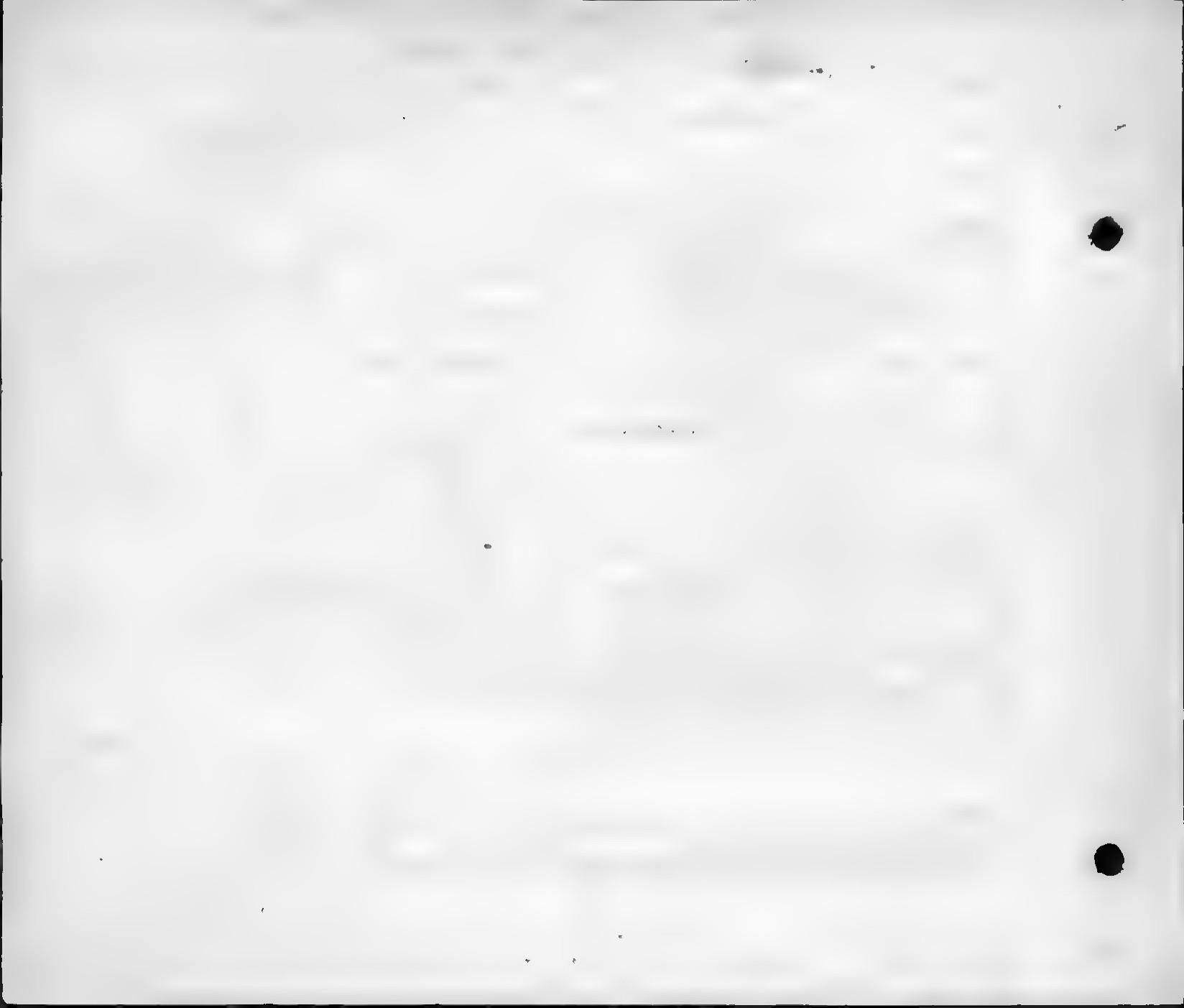
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3361

CERTIFICATE OF DEATH

Reg. Dist. No. 113350

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c. LENGTH OF STAY IN 1b <i>38 yrs</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		
3. NAME OF DECEASED (Type or print) <i>Annie Rose</i>		First <i>Schottrock</i>	Middle <i>March</i>	
4. DATE OF DEATH <i>July 26, 1891</i>	Month <i>July</i>	Day <i>26</i>	Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Cauc.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 26, 1891</i>	
9. AGE (In years to day) <i>69 yrs</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Presser</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Laundry</i>	12. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
13. FATHER'S NAME <i>William Ains worth</i>	14. MOTHER'S MAIDEN NAME <i>Unknown</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		
16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>212-20-1318</i>	17. INFORMANT <i>Ruth Ashby</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4-00</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	Address <i>309 Dean DR</i>	
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			INTERVAL BETWEEN ONSET AND DEATH <i>Years</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Hour a. m. p. m.	Month <i>November</i>	Day <i>19</i>	Year <i>60</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>309 Uirs Ln. 11 Rd.</i>	(County) <i>Holmes</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>November 19, 60</i> to <i>March 19, 61</i> , that I last saw the deceased alive on <i>10 March 1961</i> , and that death occurred at <i>7A M</i> , from the causes and on the date stated above.				
ACTUAL SIGNATURE <i>Herman C. Magazini</i>		ADDRESS (Street, city or town, state) <i>Herman C. Magazini Rockville Md.</i>		
22a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/14/61</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Rockville</i>	22d. LOCATION (City, town, or county) <i>Rockville, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Tyson Wheeler Funeral Home</i>		24a. ADDRESS <i>1331 E. Montgomery Avenue</i>	24b. REC'D BY REGISTRAR <i>Arthur S. Thrall</i>	24c. DATE <i>MAR 14 '61</i>



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please initial the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3362 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03351

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town)

Silver Spring 1 hr.

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (if not hospital, give street address)

Georgetown

3. NAME OF DECEASED

(Type or print)

4. SEX

5. COLOR OR RACE

Male White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Builder

10b. KIND OF BUSINESS OR INDUSTRY

NEW Homes

13. FATHER'S NAME

Maurice E Schreiber (Dec)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank, dates of service)

NO

16. SOC. SECUR. NO.

17. INFORMANT

578-03-2969 Edith Schreiber -

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

450.1

Conditions, if any, which
gave rise to immediate cause
(e), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

DUE TO

(d)

DUE TO

(e)

DUE TO

(f)

DUE TO

(g)

DUE TO

(h)

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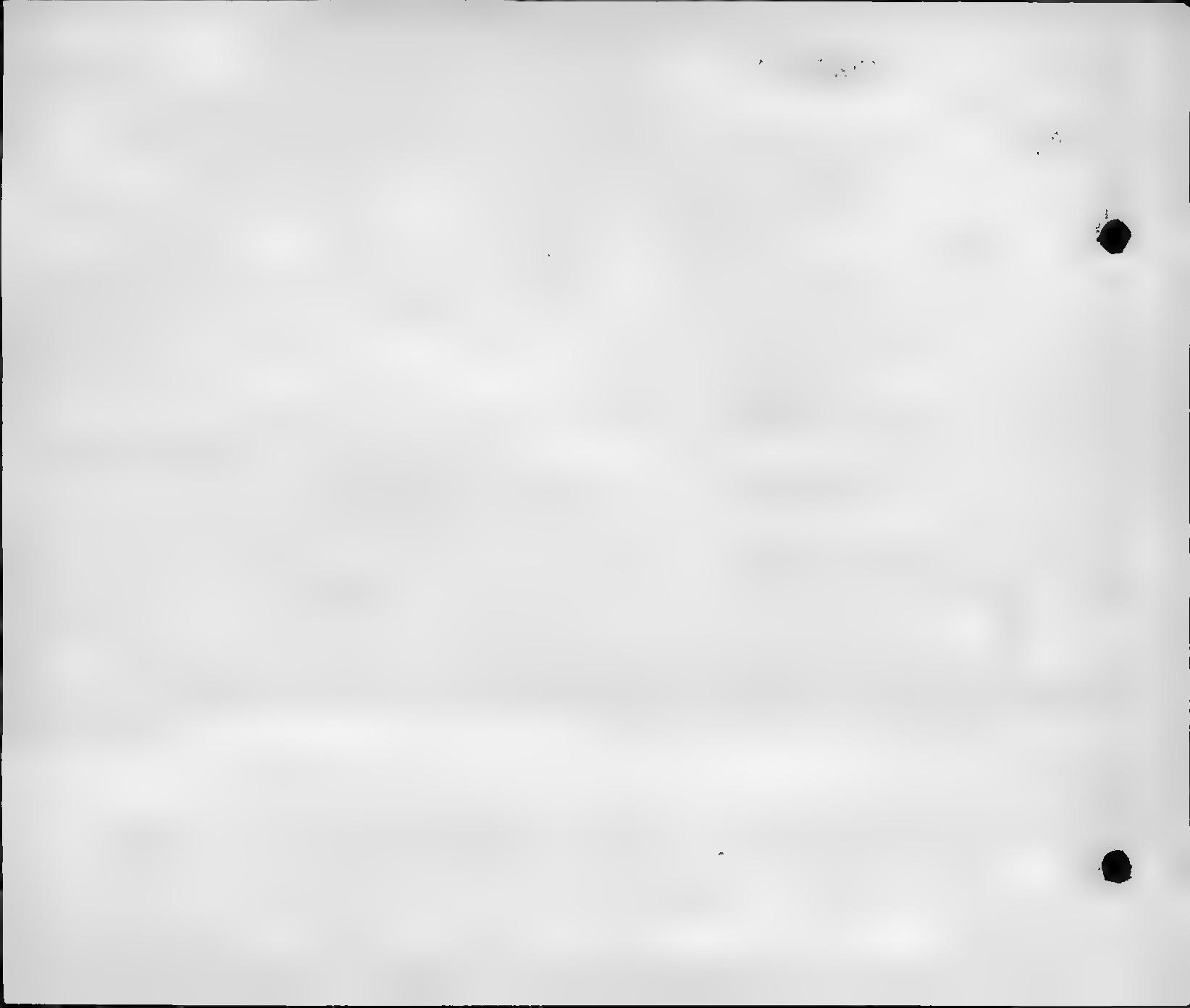
DUE TO

(qq)

DUE TO

(rr)

DUE TO



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3363

CERTIFICATE OF DEATH

13352

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached from the certificate, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR TO FILE (4)
ISM 9/60

1. PLACE OF DEATH
a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

5124 Wessling Lane

3. NAME OF
DECEASED
(Type or print)

William

First

MARYLAND

c. LENGTH OF STAY IN lb

5. SEX

Male

6. COLOR OR RACE

White

E

Middle

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

b. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

d. STREET ADDRESS

5124 Wessling Lane

e. IS RESIDENCE
ON A FARM?
YES NO

Day Year

Last

Month

Day

Year

4

19 61

19

Hours Min.

10

Months Dey

3

Mins.

10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Dentist

13. FATHER'S NAME

William E. Schumann

Dentistry

Missouri

USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank, dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Unknown

Address

None

Katharine G. Schumann - Wife - same 2d

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE

DUE TO

Conditions, if any, which
give rise to immediate cause
(c), stating the underlying
cause last,

b)

DUE TO

(c)

None

Katharine G. Schumann - Wife - same 2d

INTERVAL BETWEEN
ONSET AND DEATH

2 yrs

10 yrs

congestive heart failure
arterio sclerotic heart disease
generalized arterio sclerosis

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.
p.m.

20d. INJURY OCCURRED

While Not While
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

, County)

(State)

21. I certify that (I) (this hospital) attended the deceased from

saw the deceased alive on 3/14/1961, and that death occurred at 1 P.M. from the causes and on the date stated above

22e. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

H. F. Kreuzburg

M.D.
22d. ADDRESSATTENDING
PHYS.
MED
DIRECTOR
STAFF
PHYS.3/5/61
22b. DATE
SIGNED

7852

16

A

New

Wash

DC

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

3/7/61

23c. NAME OF CEMETERY OR CREMATORIAL
ADDRESS

Gate of Heaven Cemetery

23d. LOCATION (City, town or county)

(State)

25e. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR'S SIGNATURE

Robert A. Pumphrey

Bethesda, Maryland

DATE MAR 8 '61

Cirila S. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the State Board of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.

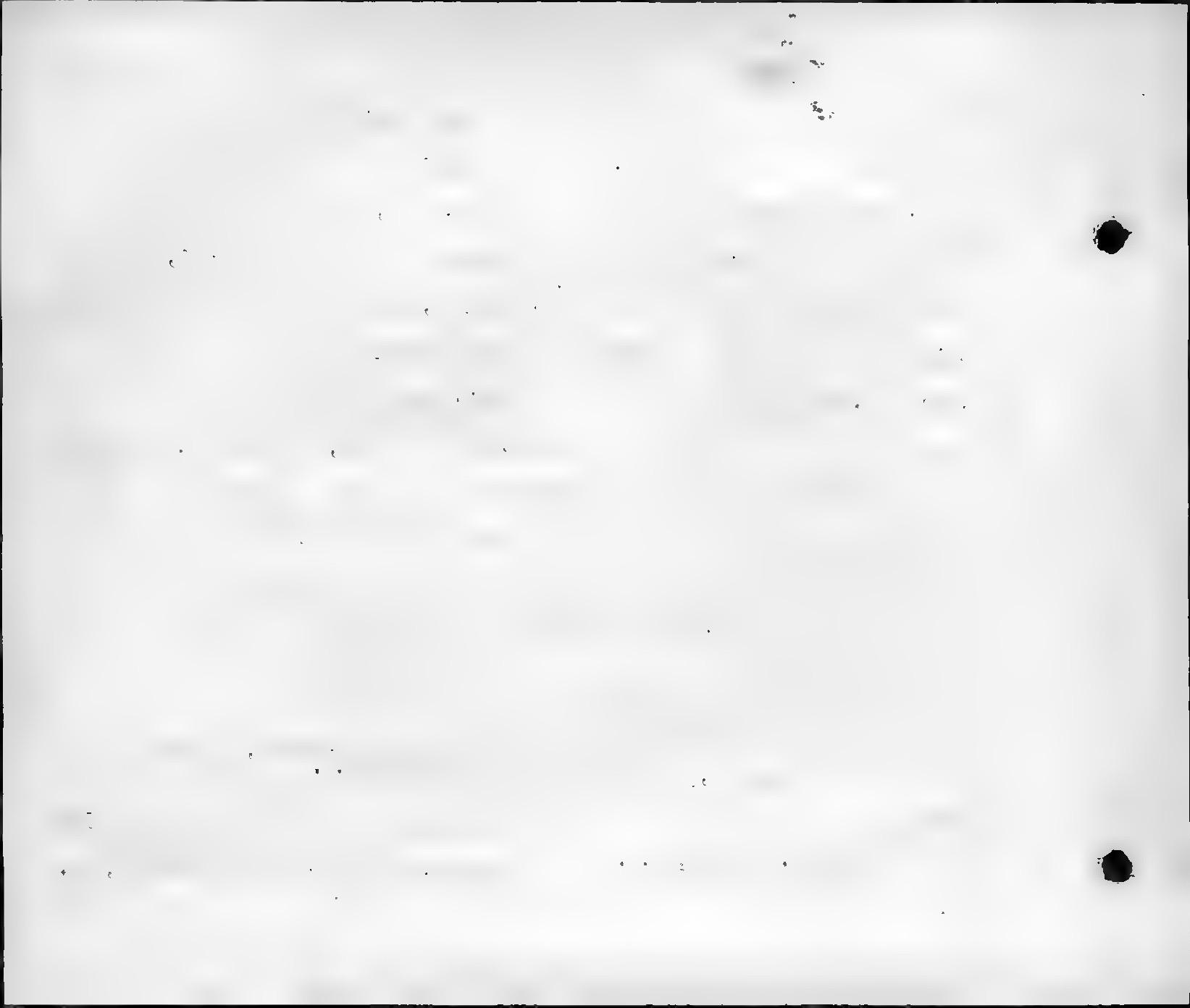
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3368

CERTIFICATE OF DEATH

13256

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE West Virginia		b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 23 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clendenin		d. STREET ADDRESS Route #4, Box 127							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Patty		First	Middle Lyn	Last Seabolt	4. DATE OF DEATH March 3, 1961	Month	Day	Year					
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 8, 1958		9. AGE (In years last birthday) 3 yrs.	10. IF UNDER 1 YEAR Months 3		11. IF UNDER 24 HRS Hours 12	12. IF UNDER 24 HRS Min 11			
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Charlie R. Seabolt				14. MOTHER'S MAIDEN NAME Wavie King									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown, If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 54 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) DUE TO (c)		<i>Atrial fibrillation & congestive heart failure by anoxic Congenital heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH 2 days Since birth							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cardiac Surgery						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Car accident		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) AMMA		(County) WEST, Va.	(State) VA
21. I certify that (I) (this hospital) attended the deceased from February 8, 1961 , to March 3, 1961 , that (I) (we) last saw the deceased alive on March 3, 1961 , and that death occurred at 11:10 a.m. M. from the causes and on the date stated above.													
22a. SIGNATURE James L. Talbert,				M.D.		ATTENDING PHYS <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS <input checked="" type="checkbox"/>	22b. DATE SIGNED 3/3/61				
22c. PHYSICIAN'S NAME (Type) JAMES L. TALBERT, M.D.						22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) SHIP AIR		23b. DATE THEREOF 3-4-61		23c. NAME OF CEMETERY OR CREMATORIAL REED'S CEMETERY		23d. LOCATION (City, town, or county) AMMA		(State) WEST, VA					
24. FUNERAL DIRECTOR'S SIGNATURE 66 W. Chamberlain Co 1400 Chapin St. NW		ADDRESS		25a. REC'D BY REGISTRAR MAR 6 '61		25b. REGISTRAR'S SIGNATURE Charles S. Kraus							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3364**CERTIFICATE OF DEATH****03357**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Montgomery		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN TB	
		55	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR N.S.T.J.T.O.N. Kensington Gardens Rest Home		d. STREET ADDRESS 4702 Essex Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Elizabeth		C	Searles
4. DATE OF DEATH		Month	Day Year
March		31	19 61
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
Female		White	
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
May 11, 1868		92 yrs.	10 20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) Delaware	
12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME Peter F. Causey		14. MOTHER'S MAIDEN NAME Jane E. Dickinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
		17. INFORMANT Mrs. Dale G. Morgan-daughter-same 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0		PULMENARY EDEMA 10 HRS.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO ARTERIOSCLEROTIC HEART DISEASE 5 Mo.			
{ (c) DUE TO ARTERIOSPLEKOSIS GENERAL 4 YRS.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 1961</u> to <u>MAR 30 1961</u> , that (I) (we) last saw the deceased alive on <u>MARCH 30 1961</u> , and that death occurred at <u>6:26 AM</u> , from the causes and on the date stated above		22b. DATE SIGNED 3-31-61	
22a. SIGNATURE <u>Leo M. Curtis</u>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Leo M. Curtis, M.D.		22d. ADDRESS 8218 Wisconsin Ave, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/3/61	
		23c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat. Cem.	
23d. LOCATION (City, town, or county) (State)		23e. REC'D BY REGISTRAR Arlington Cemetery	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25b. REGISTRAR'S SIGNATURE Clintus S. Kraus	
		ADDRESS Bethesda, Maryland	
		DATE 4/3 '61	



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please initial the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3369

03358

1. PLACE OF DEATH
a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN lb

5 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Suburban Hospital

Middle

3. NAME OF
DECEASED
(Type or print)

Charles

5. SEX

6. COLOR OR RACE

Male

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

13. FATHER'S NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or date of service)

No

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

1.3.

Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

16. SOCIAL SECURITY NO.

17. INFORMANT

None

Hospital Record

Cardio-renal failure

INTERVAL BETWEEN
ONSET AND DEATH

3 days

Open reduction fracture rt. hip

4 days

Fall in his yard

19. WAS AUTOPSY PERFORMED? YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Advanced arteriosclerosis general

YES NO

20c. TIME OF INJURY Month, Day, Year
Hour 4:00 p.m. 3/3 1961

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. CITY OR TOWN (County)

(State)

Home Gaithersbury Mont. Md.

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry , and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE *Frank J. Broschart*

CHIEF MEDICAL EXAMINER

EXAMINER'S
NAME (Type) Frank J. Broschart

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED
3/10/61

Address (Street, city, town, or county)

22a. BURIAL, CREMATION
REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CRÉMATORIUM 22d. LOCATION (City, town, or country) (State)
Burial transit 3-10-61 West Laurel Hill Cem. Philadelphia, Penna.

23. FUNERAL DIRECTOR ROBERT A. PUMPHREY ADDRESS MAR 17 '61 24b. REGISTRAR'S SIGNATURE
Bethesda, Md. DATE Arthur S. Kline

X

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician until the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

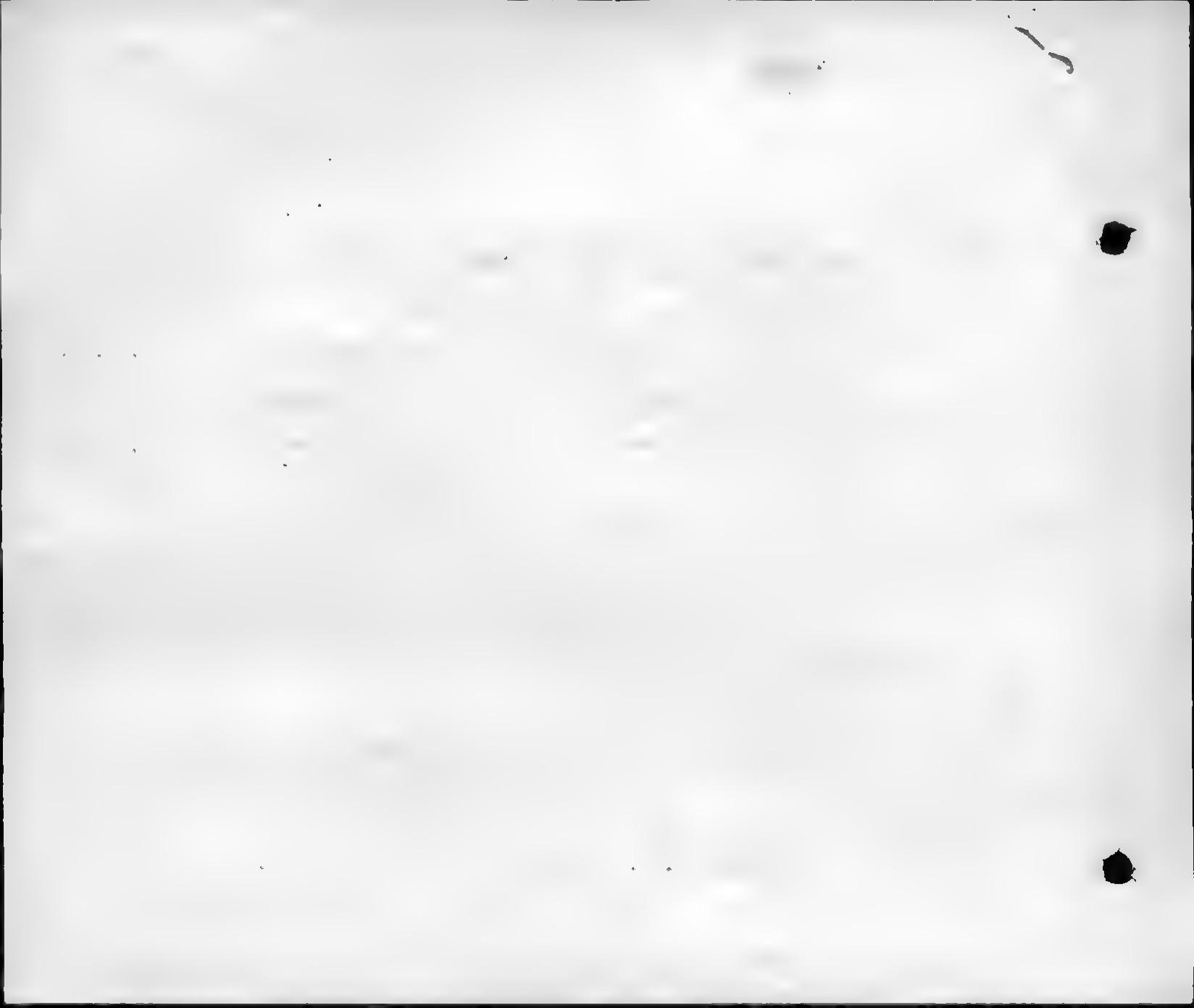
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

(13359)

3370

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG	
c. LENGTH OF STAY IN 1b 46 DAYS		d. STREET ADDRESS 103 SUMMIT AVE.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print)	First John	Middle Robert	Last Shipe
4. DATE OF DEATH MARCH 20 1961	Month Day Year		
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/4/1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME CHARLES EDWARD SHIPE		14. MOTHER'S MAIDEN NAME LUCY LEE CUNNINGHAM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-16-1627	
17. INFORMANT HOSPITAL RECORDS, OLNEY, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO <i>Pancreatitis Acute</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 1, 1961 to 3-20, 1961</i> that (I) (we) lost saw the deceased alive on <i>3-19-61</i> and that death occurred at <i>4:10 AM</i> from the causes and on the date stated above		22b. DATE SIGNED <i>3/20/61</i>	
22a. SIGNATURE <i>JACK SCHUMACHER</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) JACK SCHUMACHER, M. D.		22d. ADDRESS GAITHERSBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/22/61	
23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery		23d. LOCATION (City, town, or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
25a. REC'D BY REGISTRAR DATE MAR 23 '61		25b. REGISTRAR'S SIGNATURE <i>Orilia J. Krause</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
3365 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03353

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown		c. LENGTH OF STAY IN lb 10 hrs		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg (rural)			
						d. STREET ADDRESS RFD # 3			
						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Norman		Middle Shirley		4. DATE OF DEATH Month Mar. Day 20 Year 1961			
5. SEX Male		6. COLOR OR RACE Col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH July ? 1914		9. AGE (In years last birthday) IF UNDER 1 YEAR 46 yrs. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Shirley		14. MOTHER'S MAIDEN NAME Cora Johnson							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or details of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Wellington Shirley RFD 3 Gaithersburg, Md.							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		<i>acute myocardial infarction</i>				INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		DUE TO (b) <i>Occlusion, Atherosclerosis, Raynaud's, etc.</i>		DUE TO (c) <i>Paroxysmal A. -tachycardia</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Gaithersburg (County) Md. (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Frank J. Broschart				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED Mar. 20, 1961	
22a. BURIAL, CREMATION, REMOVAL (If Yes) Burial		22b. DATE THEREOF 3/23/61		22c. NAME OF CEMETERY OR CREMATORIAL Poplar Grove,		22d. LOCATION (City, town, or county) Gaithersburg, Md. (State) Md.			
23. FUNERAL DIRECTOR Robert L. Snowden		ADDRESS Rockville, Md.		24a. REC'D BY REG STRAR DATE MAR 23 '61		24b. REGISTRAR'S SIGNATURE Arthur E. Kline			

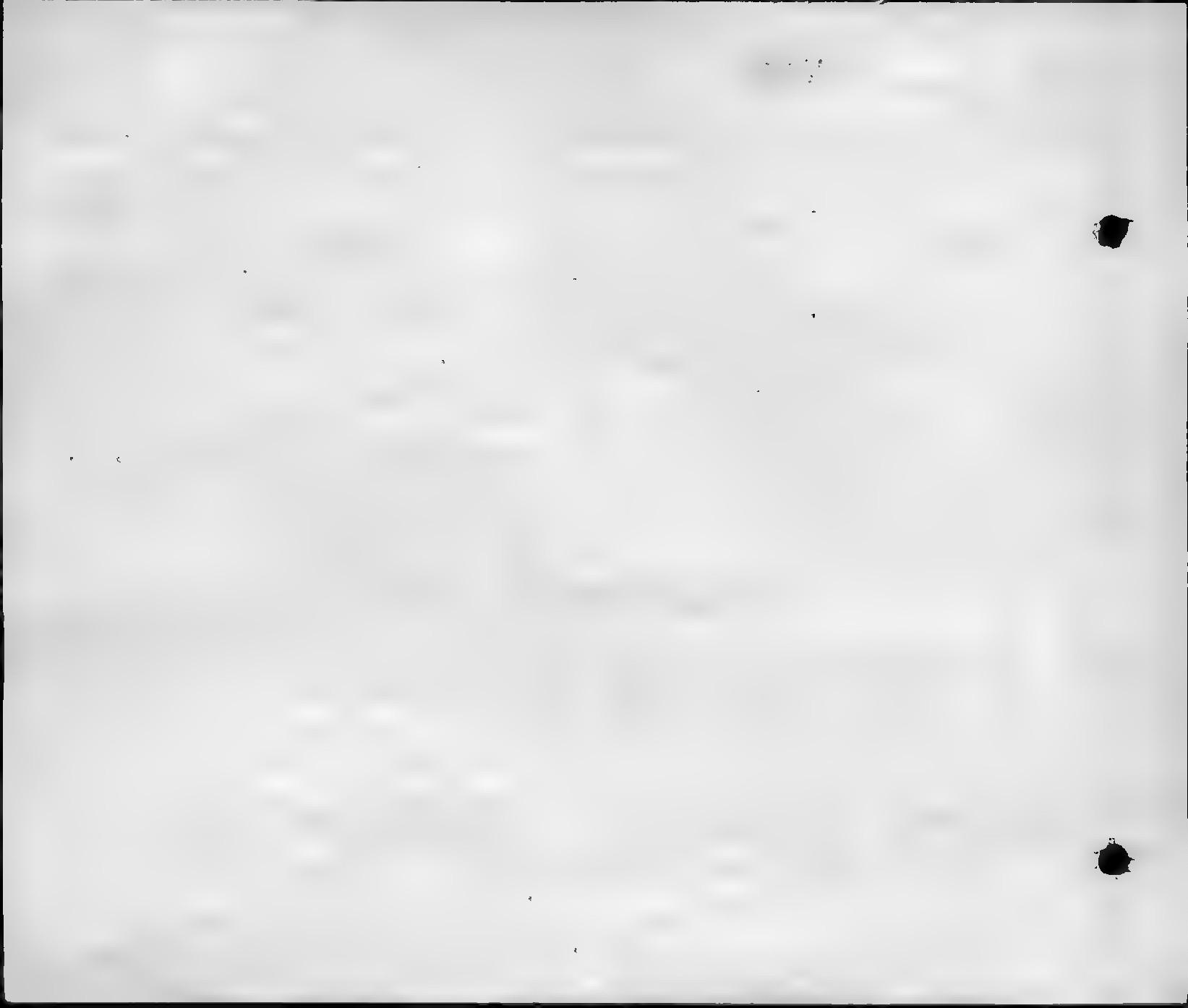
TO DEATH CERTIFICATE: This certificate should be executed within 24 hours of death. If any delay is necessary, please forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

4 should be forwarded to the Funeral Director; Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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V.S. A15ME
 SM 7/59



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3366

03354

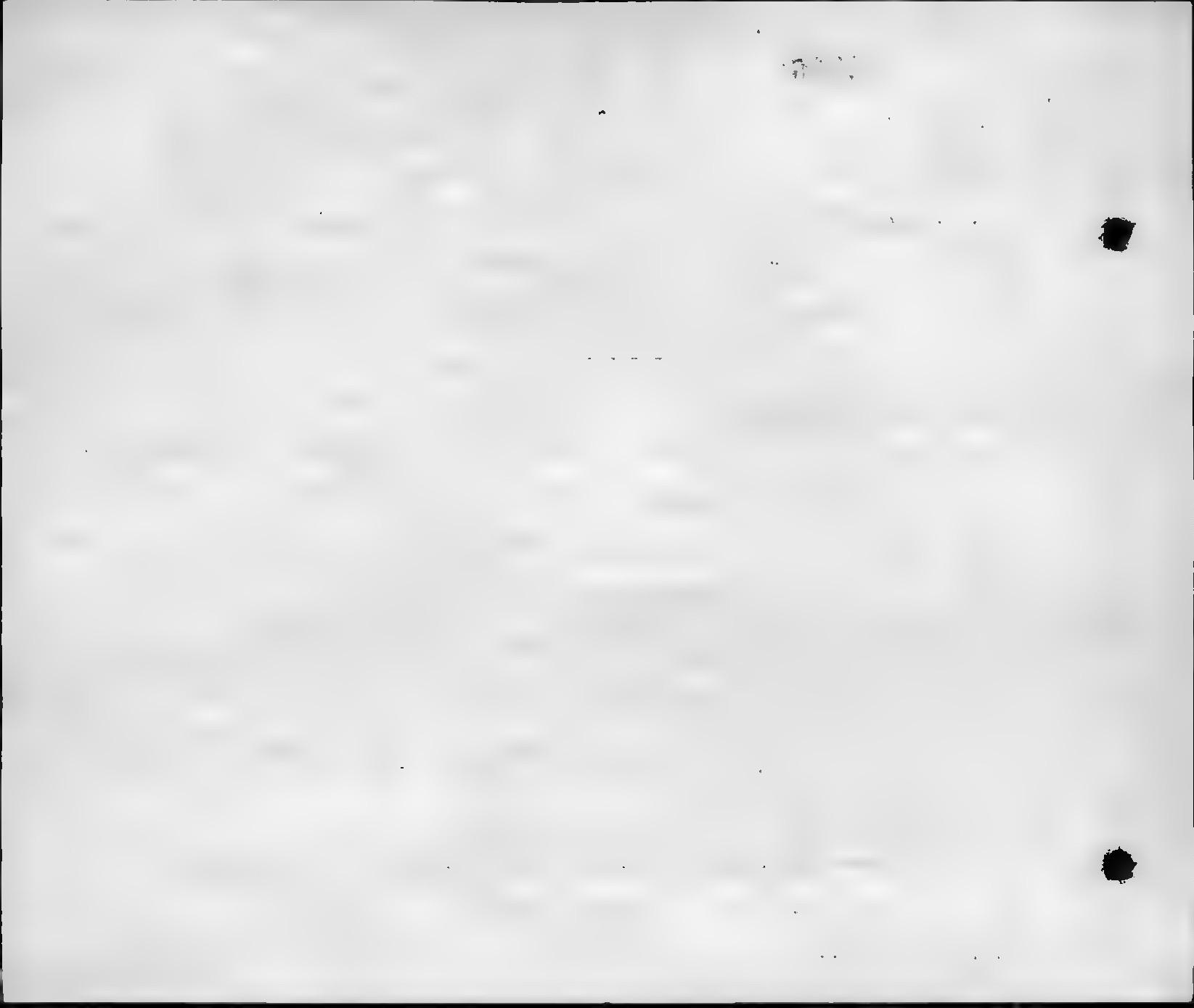
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Ohio	
b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		e. STREET ADDRESS Greenville	
3. NAME OF DECEASED (Type or print) Mark		4. DATE OF DEATH Year Month Day Year 1961 March 17 1961	
5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1-24-61	
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Kent SHIVERDECKER		14. MOTHER'S MAIDEN NAME Marcia E. GAMBANCORTA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (F) David K. Shiverdecker, same as #2 above		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Septicemia	
PART I. DEATH WAS CAUSED BY: - IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO } (c)		Pylonephritis Hydrocephrosis	
		INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
		1 mo.	
		Congenital	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) None	
20f. CITY OR TOWN None		(County) (State) None	
21. I certify that (I) (this hospital) attended the deceased from March 7, 1961 to March 17, 1961 , that (I) (we) last saw the deceased alive on March 17, 1961 , and that death occurred at None , from the causes and on the date stated above.		22b. DATE SIGNED 3-17-61	
22e. SIGNATURE Lawrence G. Thorne		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
22e. PHYSICIAN'S NAME (Type) Lawrence G. THORNE, LT, MC, USN		23d. LOCATION (City, town or county) (State) Greenville Ohio	
23a. BURIAL CREMATION REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 3-18-61	
23c. NAME OF CEMETERY OR CREMATORIAL Greenville Cemetery		23d. LOCATION (City, town or county) (State) Greenville Ohio	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., 3072 M St., NW, WashDC		25a. REC'D BY REGISTRAR DATE MAR 21 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Thorne	

VVVVVVV



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3367

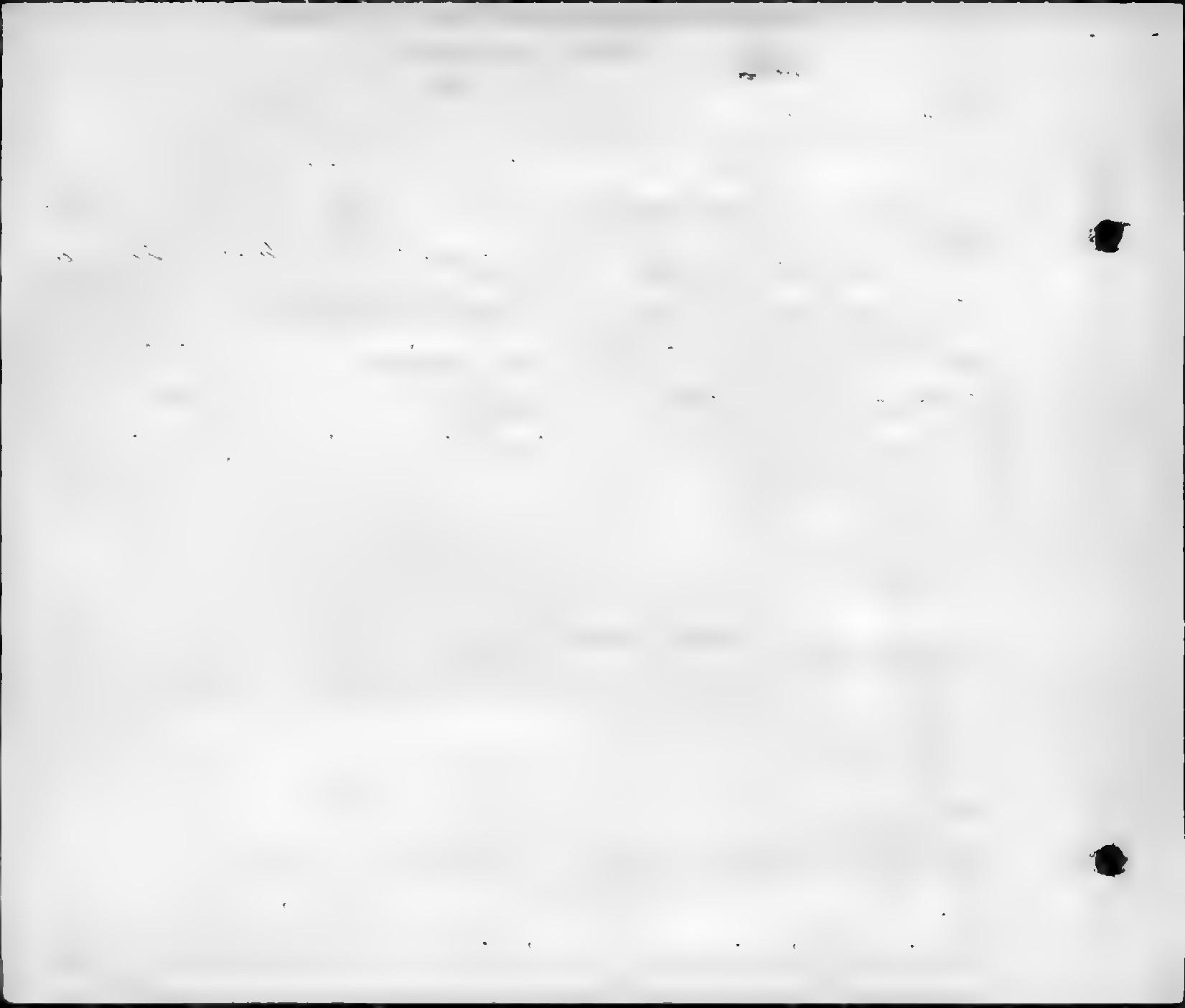
CERTIFICATE OF DEATH

Reg. Dist. No.

013355

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		d. STREET ADDRESS 3700 Dupont Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL HALL SANATORIUM				d. STREET ADDRESS 3700 Dupont Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CARRIE BELLE		First	Middle	Last	4. DATE OF DEATH S H R O A T	Month	Day	Year	
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/21/79	9. AGE (In years at birth) 8	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRESSMAKER		10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) ATLANTA, GEORGIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME LEMUEL BRIGMAN		14. MOTHER'S MAIDEN NAME CARRIE GILLIAM							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mr. Jack W. Harville, 3700 Dupont Ave.		Address KENSINGTON, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 32X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last Phlebothrombosis		Cerebral embolism				INTERVAL BETWEEN ONSET AND DEATH			
(b) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last Generalized arteriolysis									
(c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last Blood tumor removed 7/60									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) None							
20c. TIME OF INJURY Month, Day, Year Hour a. m. None 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) None		(County)	(State)
21. I certify that I attended the deceased from 12/19/61 to 12/20/61 , that I last saw the deceased alive on Dec. 23, 1961 , and that death occurred at 5:30 AM , from the causes and on the date stated above						ADDRESS (Street, city or town, state) 8505 Carroll Ave		DATE SIGNED 3/24/61	
ACTUAL SIGNATURE John B. Umhauer		M.D.							
PHYSICIAN'S NAME (Type) John B. Umhauer									
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 3/29/61		22b. DATE THEREOF 3/29/61		22c. NAME OF CEMETERY OR CREMATORIUM RIVERSIDE CEMETERY		22d. LOCATION (City, town, or county) ASHEVILLE, NORTH CAROLINA		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond J. Biskup		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE APR 3 '61		24b. REGISTRAR'S SIGNATURE John S. Krause			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

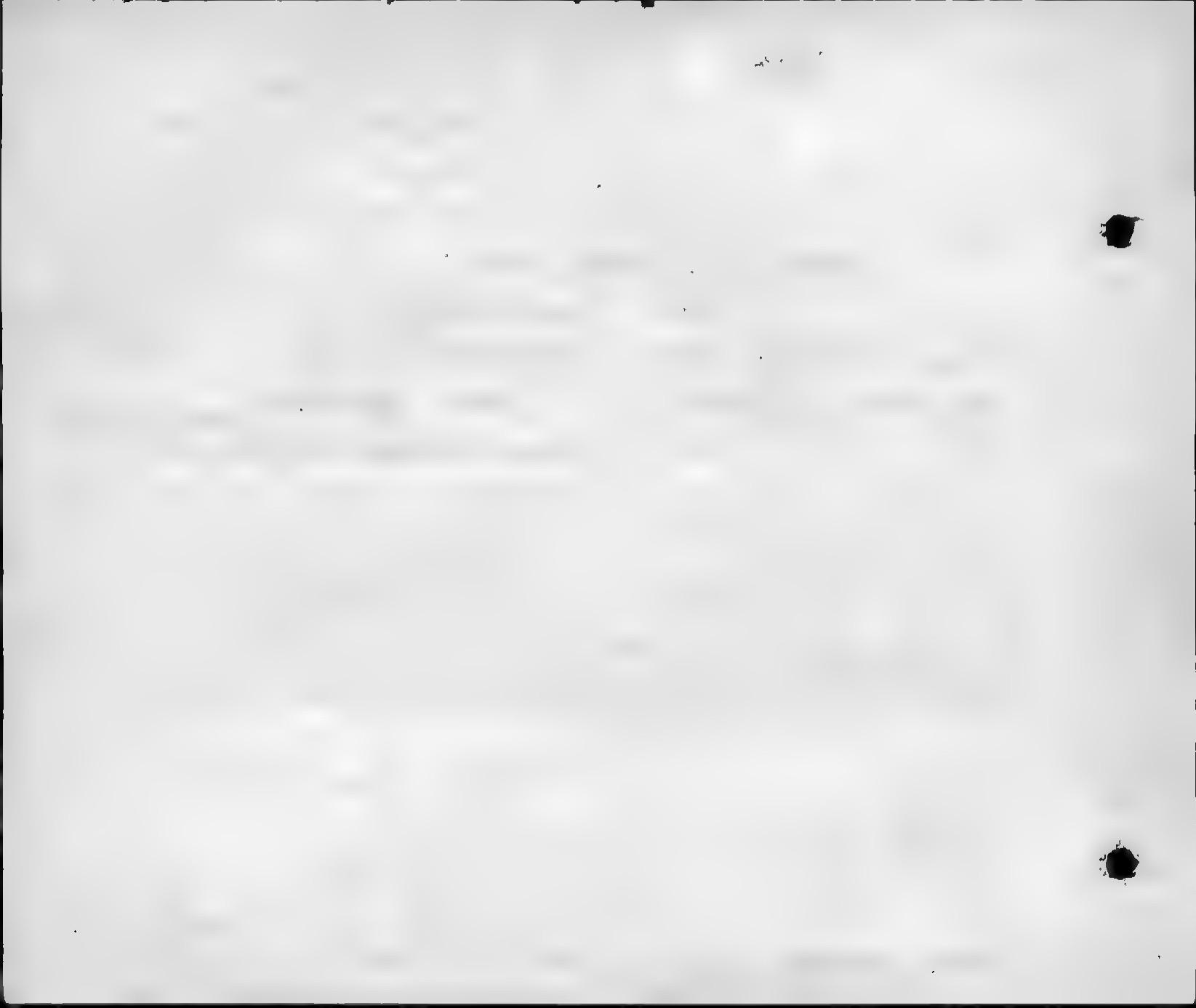
3371

CERTIFICATE OF DEATH

03360

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if Institution Residence before admission) b. STATE <i>Maine</i> b. COUNTY <i>Penobscot</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN lb MARYLAND	
4. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban Hospital</i>		d. STREET ADDRESS <i>255 Main St.</i>	
3. NAME OF DECEASED First <i>Mary</i> Middle <i>Lewis</i> Surname <i>Smart</i>		DATE OF DEATH Last <i>March 28</i> , Month <i>1961</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug 22, 1888</i>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Music Supervisor</i>		9b. AGE (in years last birthday) IF UNDER 1 YEAR <i>72 yrs.</i> Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. KIND OF BUSINESS OR INDUSTRY <i>Public schools III.</i>		10b. BTTF-P.A.C.E. (County & State, or foreign country) <i>Marion Henderson, 5913 Cheshire</i>	
13. FATHER'S NAME <i>William Cowie</i>		14. MOTHER'S MAIDEN NAME <i>Mary Wilson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, unknown) (If yes, give year and date of service) <i>No.</i>		17. INFORMANT <i>Marion Henderson, 5913 Cheshire</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) <i>Terminal Uremia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 His.</i>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <i>Extensive Carcinoma of Colon</i>		20. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
20a. TIME OF INJURY Month, Day, Year Hour a.m. <i>Jan. 1961</i> p.m. <i>19</i>		20b. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20d. (City or town) <i>6601 - Frontree Rd, Bethesda, Md.</i>		(County) <i>Montgomery</i> (State) <i>Md.</i>	
21. I certify that (I) (his/her spouse) attended the deceased from... <i>Jan. 1961</i> to <i>March 1961</i> , that (I) (we) last saw the deceased alive on <i>3-28-61</i> , and that death occurred at <i>8:53 A.M.</i> from the causes and on the date stated above.		22b. DATE SIGNED <i>3-28-61</i>	
22a. SIGNATURE <i>James W. Long, M.D.</i>		ATTENDING MED. STAFF PHYS. <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>JAMES W. LONG</i>		22d. ADDRESS <i>6601 - Frontree Rd, Bethesda, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>4/1/61</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt Pleasant Cem.</i>		23d. LOCATION (City, town or county) <i>Dexter, Maine</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Cherry Chase Funeral Home</i>		ADDRESS <i>5107 N. Lincoln Ave., Chicago, IL</i>	
		25a. REC'D. BY REGISTRAR DATE <i>APR 3 '61</i>	
		25b. REGISTRAR'S SIGNATURE <i>James S. Evans</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Box 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper A. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3372

CERTIFICATE OF DEATH

03361

1. PLACE OF DEATH

a. COUNTY
Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda

c. LENGTH OF STAY IN 1b
6½ days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Suburban Hospital

MARYLAND

e. NAME OF
DECEASED
(Type or print)

First

Middle

C.

Last

4. DATE
OF
DEATH

Month

Day

Year

f. SEX

M

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

3 - - 82

9. AGE (In years
last birthday)

79 yrs.

10. IF UNDER 1 YEAR
Months Days

Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Retired

10b. KIND OF BUSINESS OR INDUSTRY

Bt P. RR Trackman

11. BIRTHPLACE (County & State, or foreign country)

14. MOTHER'S MAIDEN NAME

13. FATHER'S NAME

Charles Smith

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

No

16. SOCIAL SECURITY NO.

705-07-7642

17. INFORMANT

Jim Smith

12. CITIZEN OF WHAT COUNTRY?

Yes

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause first. } (b)

DUE TO

cause last. } (c)

Clenebral Vascula accident

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18.
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20e. TIME OF INJURY Month, Day, Year
Hour a.m. While at work Not While at work
p.m. 19

20d. PLACE OF INJURY (Home, farm
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 3-5 1961, to 3-12 1961, that (I) (we) last saw the deceased alive on 3-11 1961, and that death occurred at 10128 CEDAR LANE KENSING TOW MD on the causes and on the date stated above.

22a. SIGNATURE

Sarah E. Glover

M.D.

ATTENDING
PHYS.

MED
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED
3-12-61

23a. BURIAL, CREMATION, 23b. DATE THEREOF
REMOVAL (Specify)

Burial 3/15/61

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

23c. NAME OF CEMETERY OR CREMATORIAL

Monocacy

23d. LOCATION (City, town or county)

Beallsville, Md.

(State)

25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

DATE MAR 16 '61

Arthur S. Lewis



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

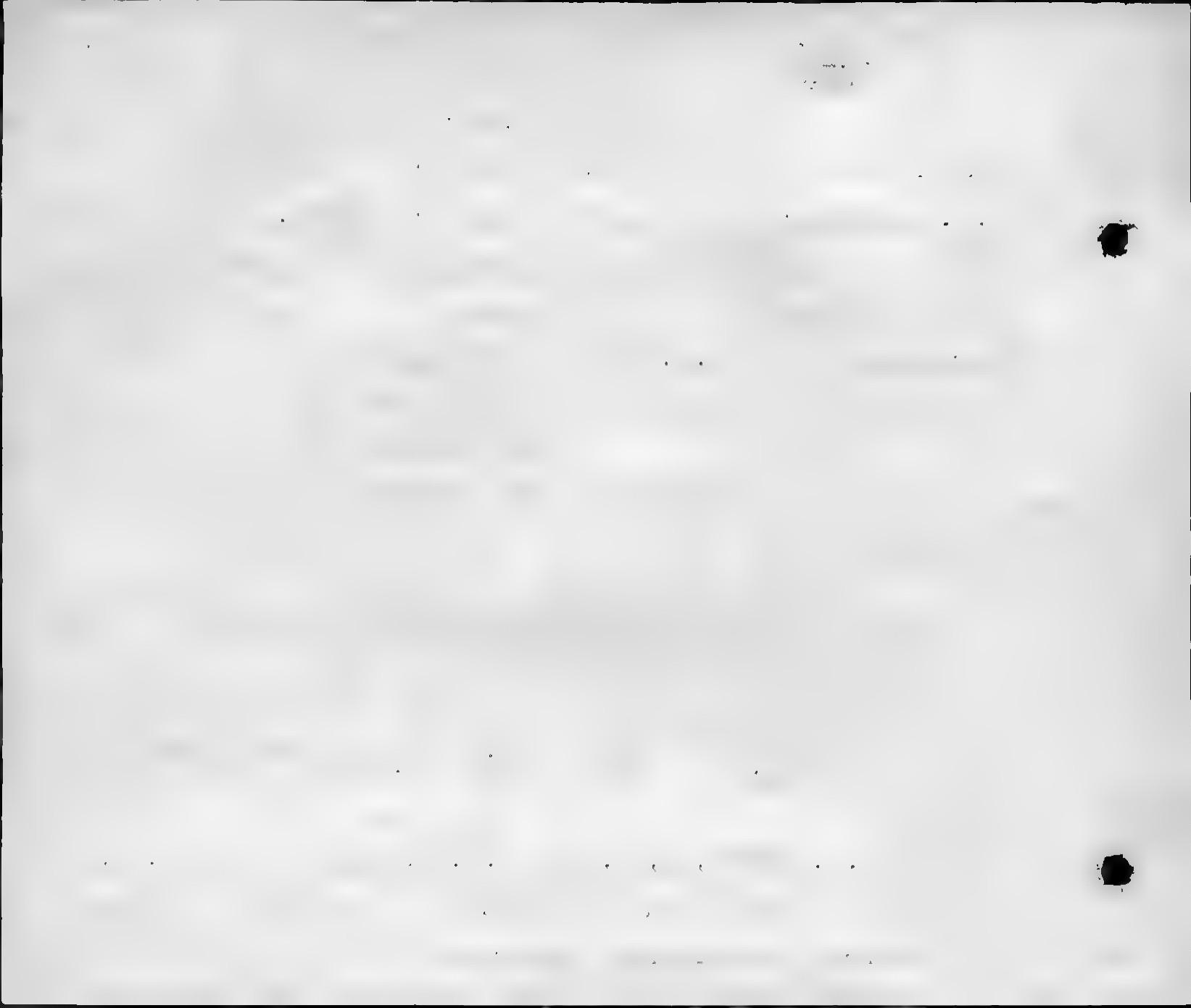
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3373

Items 2, 14, cb film 282 3-14-61 et

03362

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 26 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 4600 4004 Springdale Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		e. FIRST NAME Frank		f. MIDDLE NAME Middle		g. LAST NAME SMITH	
3. NAME OF DECEASED (Type or print) Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 2-20-73	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTH-PLACE (County & State or foreign country) Switzerland		9. AGE (In years last birthday) IF UNDER 1 YEAR 88 yrs. Months Days Hours Min.	
13. FATHER'S NAME Gustave SMITH		14. MOTHER'S MAIDEN NAME Leisha FOGLE, Elisa		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give rank or date of service) Yes 1900 to 1919		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 490X		DUE TO Right lower lobe pneumonia		INTERVAL BETWEEN ONSET AND DEATH 2-5 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. Severe coronary arteriosclerosis with remote infarction		(b) Due to		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAMED DISEASE CONDITION GIVEN IN PART I (e.g., ACCIDENT, ENVIRONMENTAL CONDITION, ETC.) Severe coronary arteriosclerosis with remote infarction		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) With		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U. S. Naval Hospital, Bethesda, Md.		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 9 1961 to March 7 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 7 1961 , and that death occurred at 3:32 AM from the causes and on the date stated above.		22a. SIGNATURE K. V. Harshman		M.D.		22b. DATE SIGNED 3-7-61	
22c. PHYSICIAN'S NAME (Type) K. V. HARSHMAN, LT, MC, USN		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-10-61		23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery		23d. LOCATION (City, town or county) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons Funeral Home, Baltimore, Md.		ADDRESS DAIR MAR 10 '61		25a. REC'D BY REGISTRAR Calvin S. Kraus		25b. REGISTRAR'S SIGNATURE	
VR A15 (4) 15M 9/60							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

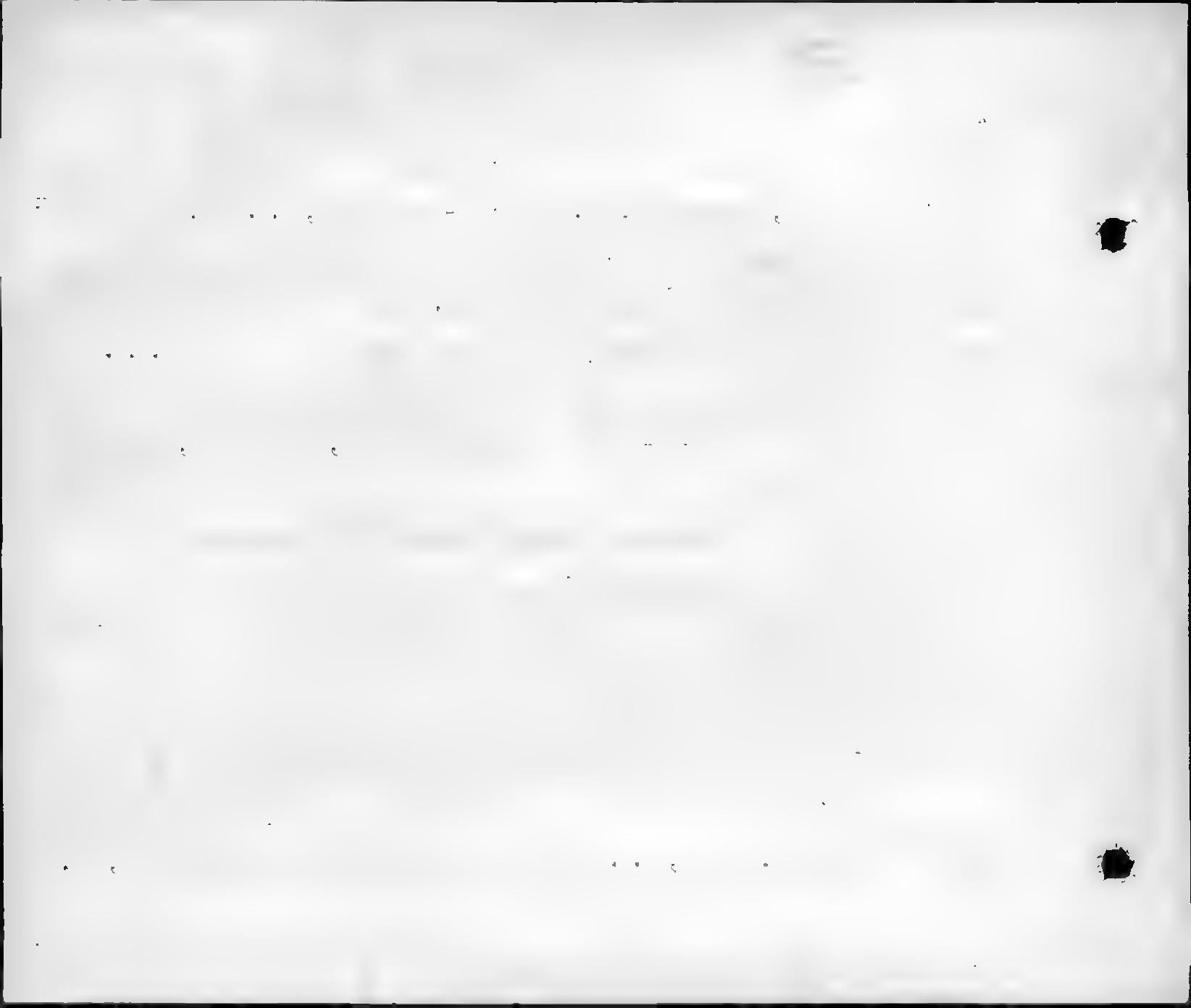
3374

CERTIFICATE OF DEATH

03363

10 HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death
may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with
 Page 33 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 10 days		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS 1631 - 6th Street, N.W. Apt. #12	
3. NAME OF DECEASED (Type or print) Hattie		First (None)	Middle	Last Smith	4. DATE OF DEATH Month March Day 27 Year 1961
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1904	9. AGE (in years last birthday) 56 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Housekeeping		11. BIRTHPLACE (State or foreign country) South Carolina	
13. FATHER'S NAME George Padgett		14. MOTHER'S MAIDEN NAME Lizzie Burtons		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 197-18-6985		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)					
i 71 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (b) ureteral Bilateral maternal obstruction & Pyelonephritis 10 days					
} DUE TO (c) Carcinoma of the Cervix 1 year					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (b) (this hospital) attended the deceased from March 17 1961 to March 27 1961 that (b) (we) last saw the deceased alive on March 27 1961 , and that death occurred at 5:30 PM from the causes and on the date stated above.					
22a. SIGNATURE Donald L. Morton		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/27/61	
22c. PHYSICIAN'S NAME (Type) Donald L. Morton, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL CREMATION REMOVAL (Specify) 3-31-61		23c. NAME OF CEMETERY OR CREMATORIAL Greenbow Nat.		23d. LOCATION (City, town, or county) (State) It's	
24. FUNERAL DIRECTOR'S SIGNATURE H.S. Washington & Sons 4925 Crane Ave NW		ADDRESS ADDRESS		25a. REC'D BY REGISTRAR DATE 3/27/61 b1	
				25b. REGISTRAR'S SIGNATURE James L. Krause	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If age 4 or over, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3375

CERTIFICATE OF DEATH

03364

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

c. LENGTH OF STAY IN lb

MARYLAND

82 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

U. S. Naval Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Roland

Diehl

SMITH

4. SEX

6. COLOR OR RACE

Male

Caucasian

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Finance

ICA, State Dept.

13. FATHER'S NAME

Harry C. SMITH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

Yes

WWII

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMED A CAUSE (a)

7 4 0 DUE TO

Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO

8 0 0 (c) DUE TO

274-16-0445 (W) Mrs. Avis M. Smith, same as #2 above

TRACHEAL OBSTRUCTION

BRONCHO PNEUMONIA

MYASTHENIA GRavis

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED While Not White
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that **W. L. Debolt** (this hospital) attended the deceased from **Dec. 22, 1960** to **March 14, 1961**, that (s) (we) last saw the deceased alive on **March 14, 1961**, and that death occurred at **M.** from the causes and on the date stated above.

22e. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

W. L. DEBOLT, LT, MC, USN

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22d. ADDRESS

22b. DATE SIGNED
3-14-61

U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION OR REMOVAL (Specify)

Burial

23b. DATE THEREOF

3-17-61

23c. NAME OF CEMETERY OR CREMATORIUM

Arlington National

23d. LOCAT ON (City, town or county)

(State)

Arlington

Virginia

24. FUNERAL DIRECTOR'S SIGNATURE

R. A. Pumphrey Funeral Home, Bethesda, Md.

ADDRESS

25a. REC'D. BY REGISTRAR

MAR 16 1961

25b. REGISTRAR'S SIGNATURE

Charles S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3376

CERTIFICATE OF DEATH

03365

1. PLACE OF DEATH

a. COUNTY MONTGOMERY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

ROCKVILLE

MARYLAND

c. LENGTH OF STAY IN lb

3 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

4509 WOODLARK PLACE

3. NAME OF
DECEASED
(Type or print)

First ANNA

Middle

Last SPIZUOCO

4. DATE
OF
DEATH

MARCH

7 1961

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED

6/7/88

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOMEMAKER

10b. KIND OF BUSINESS OR INDUSTRY

OWN HOME

11. BIRTHPLACE, County & State, or foreign country

GERMANY

9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.
72 yrs Months Days Hours Min.

13. FATHER'S NAME

FREDERICK GOTTACHAUCK

14. MOTHER'S MAIDEN NAME

ELIZABETH unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT

(Yes, no, or unknown) (If yes give war and dates of service)

Mrs. Jean Walters, 4509 Woodlark Place
Rockville, Maryland

Address

INTERVAL BETWEEN
ONSET AND DEATH

1 day

2 years

NO

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause first.

(b)

DUE TO

(c)

Congestive Heart Failure

Arteriosclerotic Heart Disease

2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Slender Melittitis

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. TIME OF INJURY	Month, Day, Year	20b. INJURY OCCURRED	20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20d. (City or town)	County	State
Hour a.m. p.m.	19	While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				

21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1961 to March 7, 1961, that (I) (was) last saw the deceased alive on March 7, 1961, and that death occurred at 8:20 p.m. from the causes and on the date stated above.

22a. SIGNATURE

John Tabb, M.D.

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. 22b. DATE SIGNED
3/7/6122c. PHYSICIAN'S
NAME (Type)

S. L. TABB, M.D.

13,000 GA. AVE. S.I. J. MD.

23a. BURIAL, CREMATION, REMOVAL (Specified)
TRANS. & BURIAL 3/11/6124. FUNERAL DIRECTOR'S SIGNATURE
WALTER E. PUMPHREY, INC.

Raymond E. Zink

23c. NAME OF CEMETERY OR CREMATORIUM
St. John's CemeteryADDRESS
SILVER SPRING, MD.23d. LOCATION (City, town or county), State
Middle Village, New York25a. REC'D. BY REGISTRAR MAR 10 1961 25b. REGISTRAR'S SIGNATURE
Clyde S. Thomas



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3377

CERTIFICATE OF DEATH

13366

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 39 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		d. STREET ADDRESS 3303 Oberon Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Mildred		First	Middle	Last	4. DATE OF DEATH March 3, 1961	Month	Day	Year
S SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1911	9. AGE (in years to nearest birthday) 49 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 MRS Months	IF JUNIOR Hours Min.
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Griffith		14. MOTHER'S MAIDEN NAME Ada V. Cross						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No) No		16. SOCIAL SECURITY NO Unascertainable		17. INFORMANT The Medical Records Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO Cardiac Failure		INTERVAL BETWEEN ONSET AND DEATH 24 hrs				
110A Conditions, if any which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO Inflow obstruction		Months				
(c)		Carcinoma of breast		Years				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from January 23, 1961 to March 3, 1961 that (I) (we) last saw the deceased alive on March 3, 1961 , and that death occurred at 4:56 PM from the causes and on the date stated above.								
22a. SIGNATURE Benjamin J. Borowsky		M.D.		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 3/4/61	
22c. PHYSICIAN'S NAME (Type) Benjamin J. Borowsky M.D.		22d. ADDRESS The Clinical Center National Institutes Of Health, Bethesda 14, Maryland						
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 3/6/61		23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery		23d. LOCATION (City, town, or county) Rockville, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR MAR 8 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas		



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Form 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached from the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3378

03367

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town]

Takoma Park

c. LENGTH OF STAY IN 1b

MARYLAND

11 days

d. NAME OF HOSPITAL OR INSTITUTION [if not in hospital, give street address]

Washington Sanitarium & Hospital

e. NAME OF
DECEASED
(Type or print)

First

Middle

WALTER

Henry

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

10a. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired]

Self-employed

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Iowa

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Samuel L. SWARTZ

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes, give number and date of service)

No

17. INFORMANT

BERTHA SCHWARTZ

Address

Hospital Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY;

IMMEDIATE CAUSE (a)

IX DUE TO

Conditions, if any, which

gave rise to immediate cause

(b) (c), stating the underlying

cause, etc.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If death occurs at home or in a hospital, the physician or attending physician may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03368

1 2
M 3379

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN [If out of corporate limits, write RURAL and give nearest town]

Bethesda (Rural)

c. LENGTH OF STAY IN 16

MARYLAND

40 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

U. S. Naval Hospital

3. NAME OF DECEASED
(Type or print)

Renee

Warfield

First

Middle

5. SEX

6. COLOR OR RACE

Female

Caucasian

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

13. FATHER'S NAME

Rene WARFIELD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

575-16-8803 (H) EGEN S. G. Taxis, USMC, Ret., same as #2

18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Adenocarcinoma, breast, with metastases

70
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

5 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While Not While
p.m. at work at work
19

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (s) (this hospital) attended the deceased from Jan. 26, 1961 to March 7, 1961, that (s) (we) last saw the deceased alive on March 7, 1961, and that death occurred at 11:35 AM, from the causes and on the date stated above.

22a. SIGNATURE

J. J. RYSKAMP, JR., LT, MC, USN

U. S. Naval Hospital, Bethesda, Md.

ATTENDING
M.D. PHYS
MED. DIRECTOR STAFF PHYS.

22b. DATE
SIGNED
3-7-61

22c. PHYSICIAN'S
NAME (Type)

23a. BURIAL, CREMATION, REMOVAL Spec f'y)

Burial 3-10-61

23c. NAME OF CEMETERY OR CREMATORI

23d. LOCATION (City, town or county)

(State)

Arlington National

Arlington

Virginia

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS

W.W. Chambers Co., 3072 M St., NW, Washington, D. C.

25a. REC'D BY REGISTRAR

MAR 9 '61

25b. REGISTRAR'S SIGNATURE

Arthur L. Thomas

)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03369

3380

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE		
<i>Montgomery</i> MARYLAND		Virginia		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>6 1/2 yrs</i>		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS <i>Arlington- 723-22nd St. S.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Foundation</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Blanche</i>		First	Middle	
		LAST	Thomas	
4. DATE OF DEATH		Month	Day	
S. SEX <i>F</i>		Year		
5. COLOR OR RACE <i>W</i>		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>July 21, 1872</i>	8. AGE (In years last birthday) <i>88 yrs</i>
9. IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		
11. BIRTHPLACE (State or foreign country) <i>Cleveland - Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>William? Newes</i>		14. MOTHER'S MAIDEN NAME <i>Cassetta Baldwin</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		
17. INFORMANT <i>Hospital Records</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>450.00</i> <i>Alveocil Preewein left lung</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Fall & bumping to left chest wall</i> DUE TO <i>Sonile gen. cert. Selesse</i> DUE TO INTERVAL BETWEEN ONSET AND DEATH <i>3 day</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While Nat while at work <input type="checkbox"/> of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>9-23-1954</i> to <i>3-12-1961</i> , that (I) (we) last saw the deceased alive on <i>12 May 1961</i> , and that death occurred on <i>14 PM</i> , from the causes and on the date stated above		22b. DATE SIGNED		
22a. SIGNATURE <i>Jane B. Siegler</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) <i>JOHN B. SIEGLER</i>		22d. ADDRESS <i>Olney, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>March 15 1961</i>		
23c. NAME OF CEMETERY OR CREMATORIAL <i>Laytonsville</i>		23d. LOCATION (City, town, or county) <i>Laytonsville</i> (State) <i>Md.</i>		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Francis H. Parker Laytonsville Md</i>		25a. REC'D BY REGISTRAR DATE <i>MAR 16 '61</i>		
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>		

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C
I

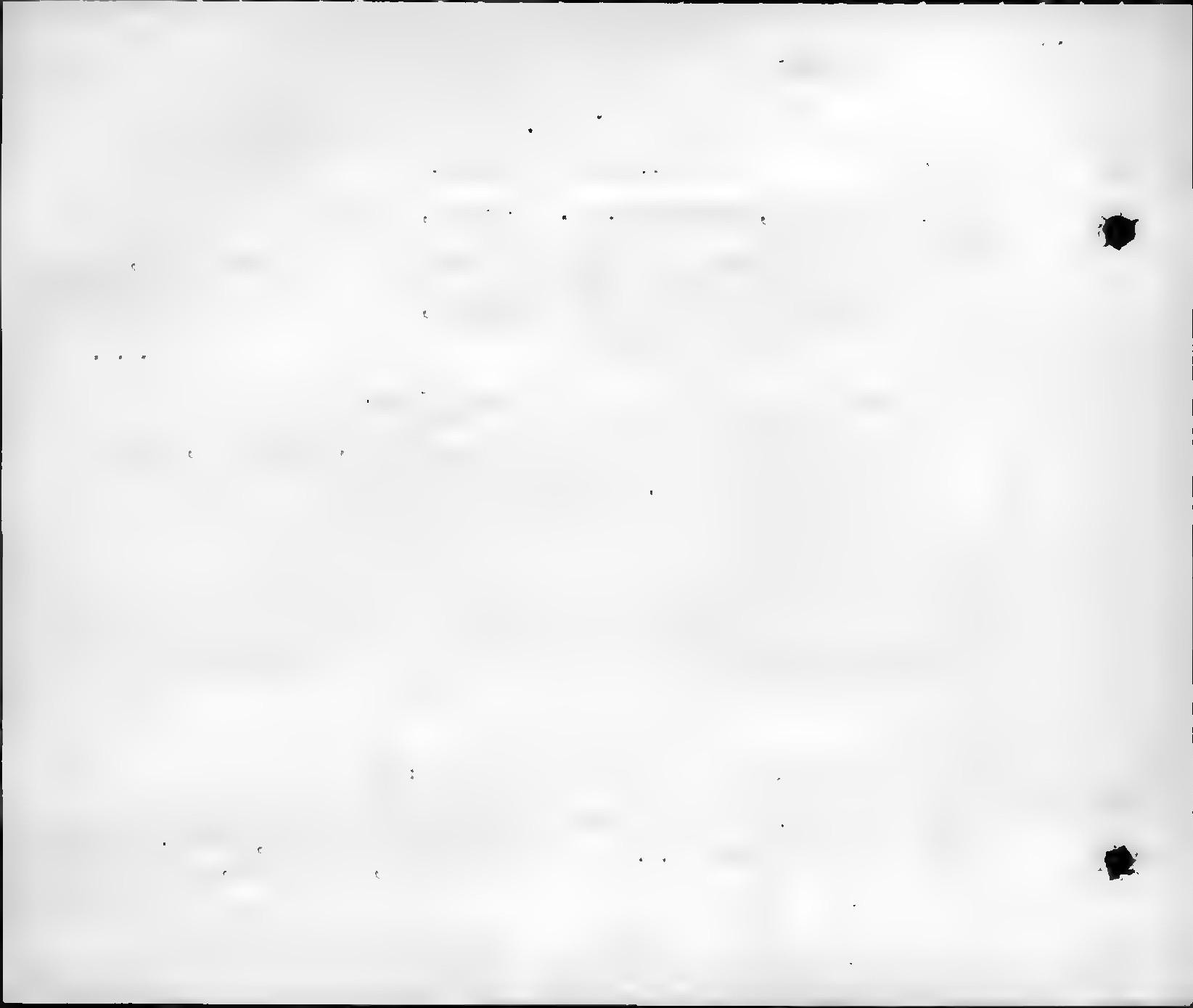
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3381

CERTIFICATE OF DEATH

03370

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) a. STATE Virginia		b. CO. COUNTY Prince William	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 11 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Triangle			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Route 1, Box 69		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Teresa	Middle Lynn	Last Thurston	4. DATE OF DEATH March 3, 1961	Month March	Day 3	Year 1961
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1961	9. AGE (in years last birthday) yrs 2	IF UNDER 1 YEAR IF UNDER 24 HRS Months 2	Days 2	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Thurston		14. MOTHER'S MAIDEN NAME Janice Bourne					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Right Heart Failure							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cystic Fibrosis of Pancreas							
DUE TO							
(c)							
INTERVAL BETWEEN ONSET AND DEATH One hour							
2 Months							
2 Days							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from February 20, 1961 to March 3, 1961 , that (I) (we) last saw the deceased alive on March 3, 1961 , and that death occurred at 3:05 AM from the causes and on the date stated above							
22a. SIGNATURE Philip Fireman M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/> 3/3/61	
22c. PHYS. CIAN'S NAME (Type) Philip Fireman M.D.		22d. PLACE OF DEATH The Clinical Center, National Institutes of Health, Bethesda 14, Maryland					
23a. BURIAL CREMATION, REMOVAL (Specify) Burial Mar 5-1961		23b. DATE THEREOF Mar 5-1961		23c. NAME OF CEMETERY OR CREMATORIAL Dunbar		23d. LOCATION (City, town or county) (State) Dunbar	
24. FUNERAL DIRECTOR'S SIGNATURE Hall Funeral Home, Belvoir, Va.		ADDRESS		25a. REG'D BY REGISTRAR MAR 17 1961		25b. REGISTRAR'S SIGNATURE Arthur S. Krause	
				DATE			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

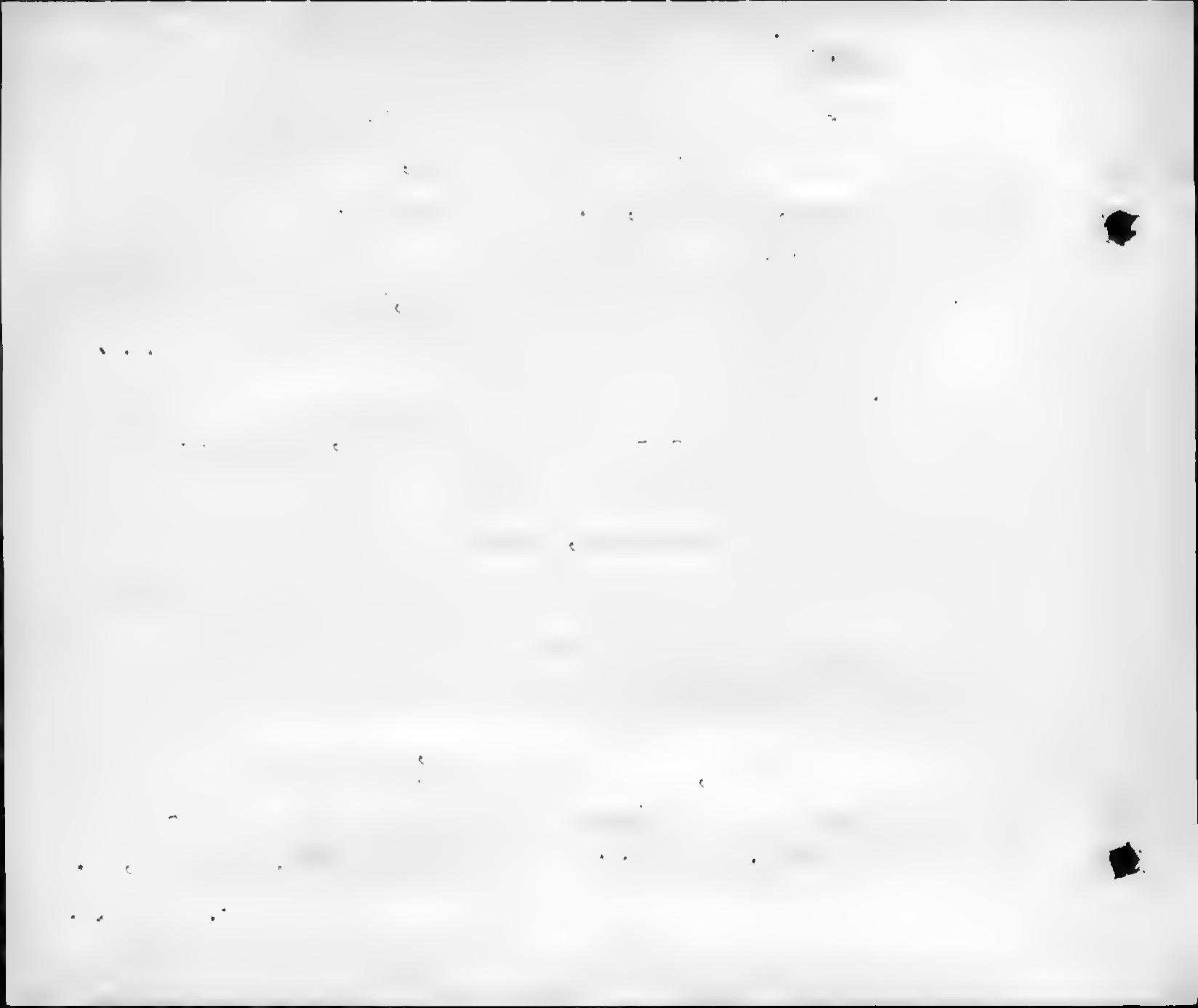
CERTIFICATE OF DEATH

03371

3382

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE New York		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 209 Days		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bronx 69		d. STREET ADDRESS 3467 Fish Avenue		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Trandafilos		First Ralph	Middle Traikos	Locality Lat	4. DATE OF DEATH March 30, 1961	Month March	Day 30	Year 1961
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 15, 1915		9. AGE (In years last birthday) 45 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk		10b. KIND OF BUSINESS OR INDUSTRY Factory		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME A. Casto Traikos				14. MOTHER'S MAIDEN NAME Athena Geranderos				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO WV II		17. INFORMANT The Medical Records Address The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Insufficiency						INTERVAL BETWEEN ONSET AND DEATH 2 Days		
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. { (b) Chondrosarcoma, Extensive		DUE TO				3 Years		
(c)		DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that (I) (this hospital) attended the deceased from September 2, 1960 to March 30, 1961, that (I) (we) last saw the deceased alive on March 30, 1961, and that death occurred at 10:00 P.M. on the causes and on the date stated above.								
22a. SIGNATURE Haskins K. Kashima M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 3-30-61		
22c. PHYSICIAN'S NAME (Type) Haskins K. Kashima M.D.				22d. ADDRESS National Institutes Of Health The Clinical Center, Bethesda 14, Md.				
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/31/61		23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery		23d. LOCATION (City, town, or county) Bronx.		(State) N.Y.
24. FUNERAL DIRECTOR'S SIGNATURE The J.H. Hanes Co.		ADDRESS 2901-14th St. N.W.		25a. REC'D BY REGISTRAR Date MAR 3 1961		25b. REGISTRAR'S SIGNATURE Haskins K. Kashima		



FOR STATE
HEALTH DEPT.



TO FUNERAL DIRECTOR: This certificate should be executed within 24 hours after death. If any delay is necessary, please file the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3383 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03372

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

BROOKVILLE, MD. Silver Spring 6 Years

c. LENGTH OF STAY IN lb

MARYLAND

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

4010 Harvard St. Havard St.

3. NAME OF
DECEASED
(Type or print)

First

Middle

John

Crawford

4. SEX

6. COLOR OR RACE

Male

White

10a. USUAL OCCUPATION (Give kind of work
done during most of work week)

bartender

Retired M/Sgt

13. FATHER'S NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

YES

WW #1 & #2

16. SOCIAL SECURITY NO.

113-20-9434

17. INFORMANT

Mrs. Blanche Turner

Address

Havard
4010 Harvard St.

BROOKVILLE, MD.
Silver Spring
INTERVAL BETWEEN
DEATH AND AUTOPSY
FEB 27 1961
in bath room

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

20e. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING

CAUSE OF DEATH:

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month Day, Year
Hour e.m.
p.m. 19

20d. INJURY OCCURRED
Wh Is Not White
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DATE SIGNED

ACTUAL
SIGNATURE

James J. Broschart

DEPUTY MEDICAL EXAMINER

Mar. 21, 1961

Address (Street, city, town, or county)

(State)

22e. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

3/24/61

22c. NAME OF CEMETERY OR CREMATORIUM

ARLINGTON NAT'L CEMETERY ARLINGTON, VIRGINIA

22d. LOCATION (City, town, or country)

SILVER SPRING, MD.

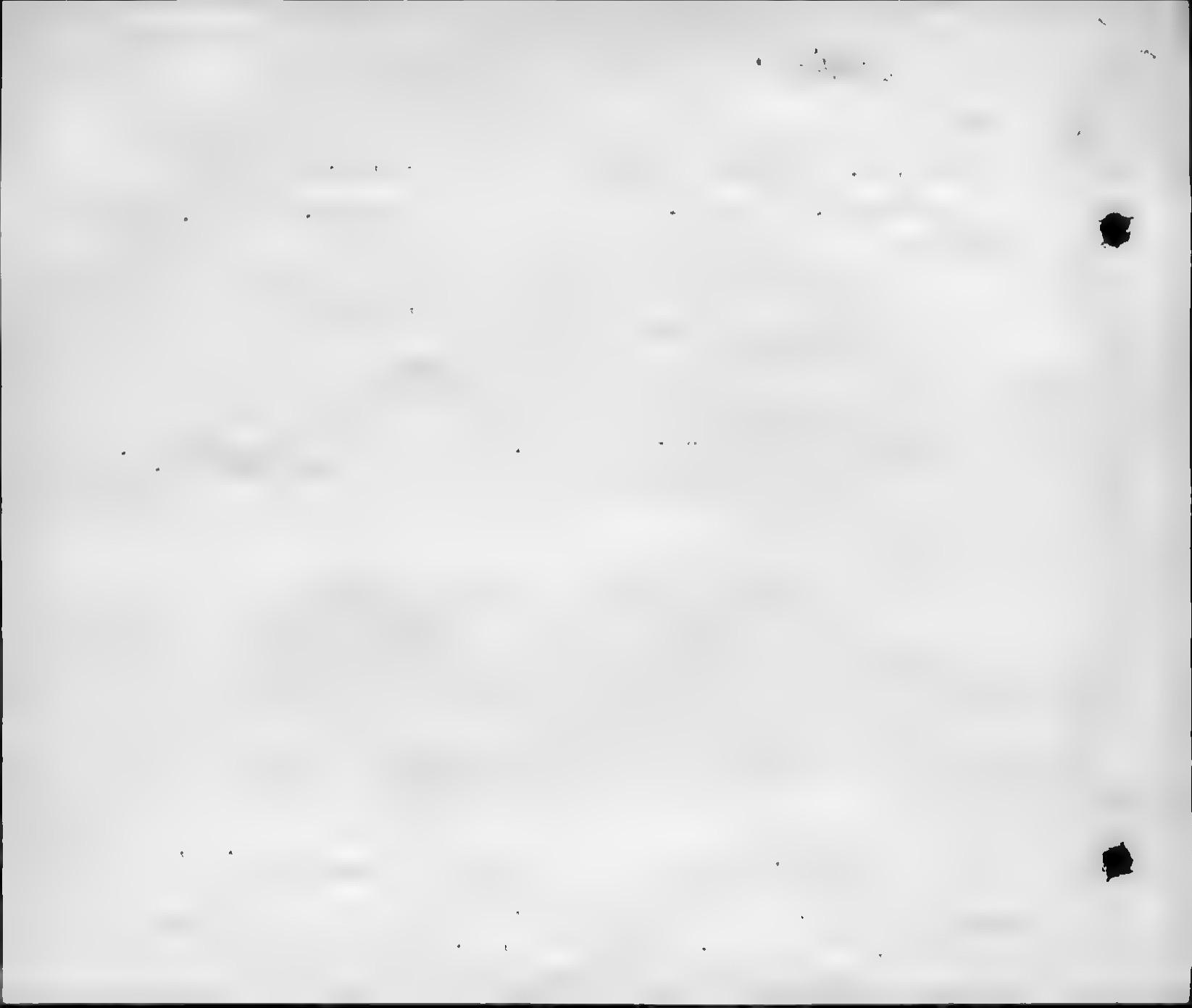
(State)

24e. REC'D BY REGISTRAR

MAR 27 '61

24f. REGISTRAR'S SIGNATURE

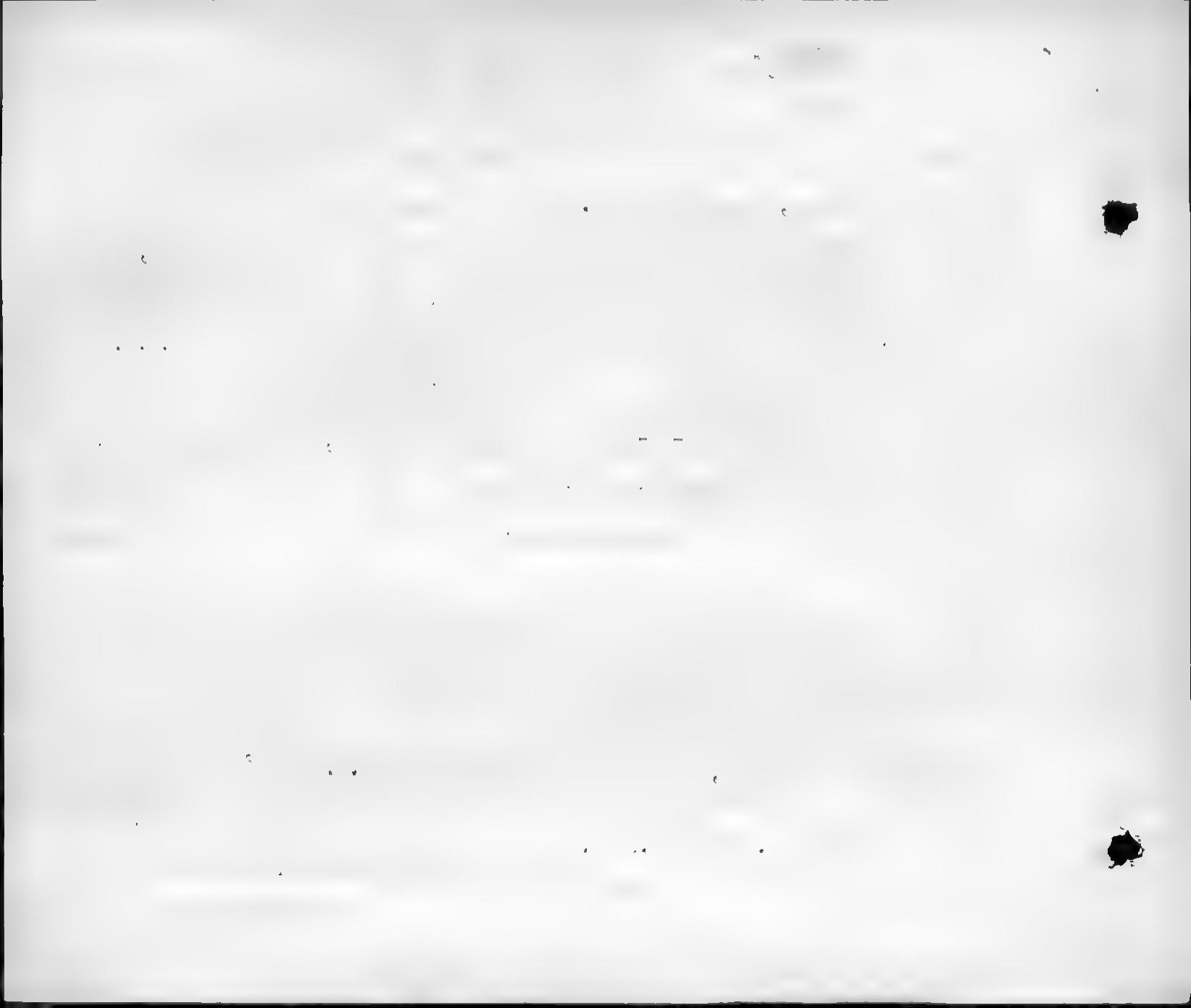
Arthur S. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND																	
CERTIFICATE OF DEATH																	
3384 Items 1-1b, 10-11b, 16-22, 24-26, 29-31				03373													
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission) a. STATE Georgia b. COUNTY													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN lb 86 Days													
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Thunderbolt													
3. NAME OF DECEASED (Type or print) Raymond Franklin				First Raymond Middle Franklin Last Unglesbee		4. DATE OF DEATH March 1, 1961		Month March Day 1 Year 1961									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 18, 1908		9. AGE (In years last birthday) 52 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.							
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				10b. KIND OF BUSINESS OR INDUSTRY Factory Hotel				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Clifford Unglesbee						14. MOTHER'S MAIDEN NAME Minnie Warfield											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212-21-0442		17. INFORMANT The Medical Records Address The Clinical Center, Bethesda 14, Maryland													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]																	
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple myeloma DUE TO (c)																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from December 5, 1960, to March 1, 1961, that (I) (we) last saw the deceased alive on March 1, 1961, and that death occurred at 1:45 A.M. from the causes and on the date stated above.																	
22a. SIGNATURE Vincent H. Bono, Jr.				22b. DATE SIGNED 3/1/61													
22c. PHYSICIAN'S NAME (Type) VINCENT H. BONO, JR., MD.				22d. ADDRESS The Clinical Center National Institutes Of Health Bethesda 14, Maryland													
23a. BURIAL, CREMATION OR REMOVAL (Specify) Bur-Transit 3/3/61				23b. DATE THEREOF 1961				23c. METHOD OF CREMATORIUM Abby Cemetery				23d. LOCATION (City, town, or county) Savannah, Georgia					
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey Bethesda, Maryland																	
ADDRESS Robert A. Pumphrey Bethesda, Maryland						25a. REC'D BY REGISTRAR MAR 2 '61						25b. REGISTRAR'S SIGNATURE Chalmers G. Knapp					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3385

CERTIFICATE OF DEATH

Reg. Dist. No. 03374

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park,		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 07 Gaithersburg,				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hospital		d. STREET ADDRESS 7 James Street,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH Month Ward	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 15, 1961	9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? America		
13. FATHER'S NAME Carlton Wendell Ward		14. MOTHER'S MAIDEN NAME Sandra - Norson						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. no		17. INFORMANT father		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), listing the under- lying cause last. Anemia						INTERVAL BETWEEN ONSET AND DEATH 3 days		
(b) DUE TO Prepartum								
(c) Partial Separation of Placenta								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Doy	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 911 Silver Spring Ave., Silver Spring, Md.	(County)	(State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED								
ACTUAL SIGNATURE <i>Carlton W. Ward</i>		M.D. 911 Silver Spring Ave., Silver Spring, Md.						
PHYSICIAN'S NAME (Type) Wallace N. McCune, M. D.		911 Silver Spring Ave., Silver Spring, Md.						
22a. BURIAL, CREMATION, OR BURIAL & CREAMATION (Specify) Burial		22b. DATE THEREOF March 16 1961		22c. NAME OF CEMETERY OR CREMATORIAL Wesley Grove		22d. LOCATION (City, town, or county) Woodfield		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frances H. Barber</i>		ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR DATE MAR 17 '61		24b. REGISTRAR'S SIGNATURE <i>Curtis S. Kraus</i>		



1
FOR STATE
HEALTH DEPT.



TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any part of the certificate, writing the word "pending" in pencil in Item 18, Give Pages 1, 2, and 3 to the Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3386 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03375

1. PLACE OF DEATH
a. COUNTY

3327-122225-5-54
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Tuckahoe

c. LENGTH OF STAY IN TB

MARYLAND

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Wicomico General Hospital

20 A.

NAME OF
DECEASED
(Type or print)

First

Middle

Gillard

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE

b. COUNTY

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Wash. D. C.

d. STREET ADDRESS

143 Rhode Island Avenue, N.W.

8. IS RESIDENCE
ON A FARM?
YES NO

Last Month Day Year

3 20 1961

9. AGE (In years
last birthday) 60 yrs

IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Labour

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

GEORGIA

13. FATHER'S NAME

James Watt

14. MOTHER'S MAIDEN NAME

Mrs. Betty

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war and dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Hosp. Record

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CEREBRAL HEMORRHAGE AND LACERATIONS

DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) MULTIPLE COMPOUND FRACTURES OF SKULL

DUE TO

(c) FALL FROM SCAFFOLD

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Fell 22 ft from scaffold on construction job

20c. TIME OF INJURY Month, Day, Year Hour

3-20 1961 2:00 p.m.

20d. INJURY OCCURRED While Not While at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

school construction Takoma Park Maryland

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

ACTUAL SIGNATURE FRANK J. Bloschart

EXAMINER'S NAME (Type) FRANK J. Bloschart

M.D. ASSISTANT MEDICAL EXAMINER

DATE SIGNED 3-20-61

22a. BURIAL, CREMATION OR REBURIAL (Specify) 22b. DATE THEREOF

Burial 3-24-1961

22c. NAME OF CEMETERY OR CREMATORY

Woodlawn Cemetery

22d. LOCATION (City, town, or county) (State)

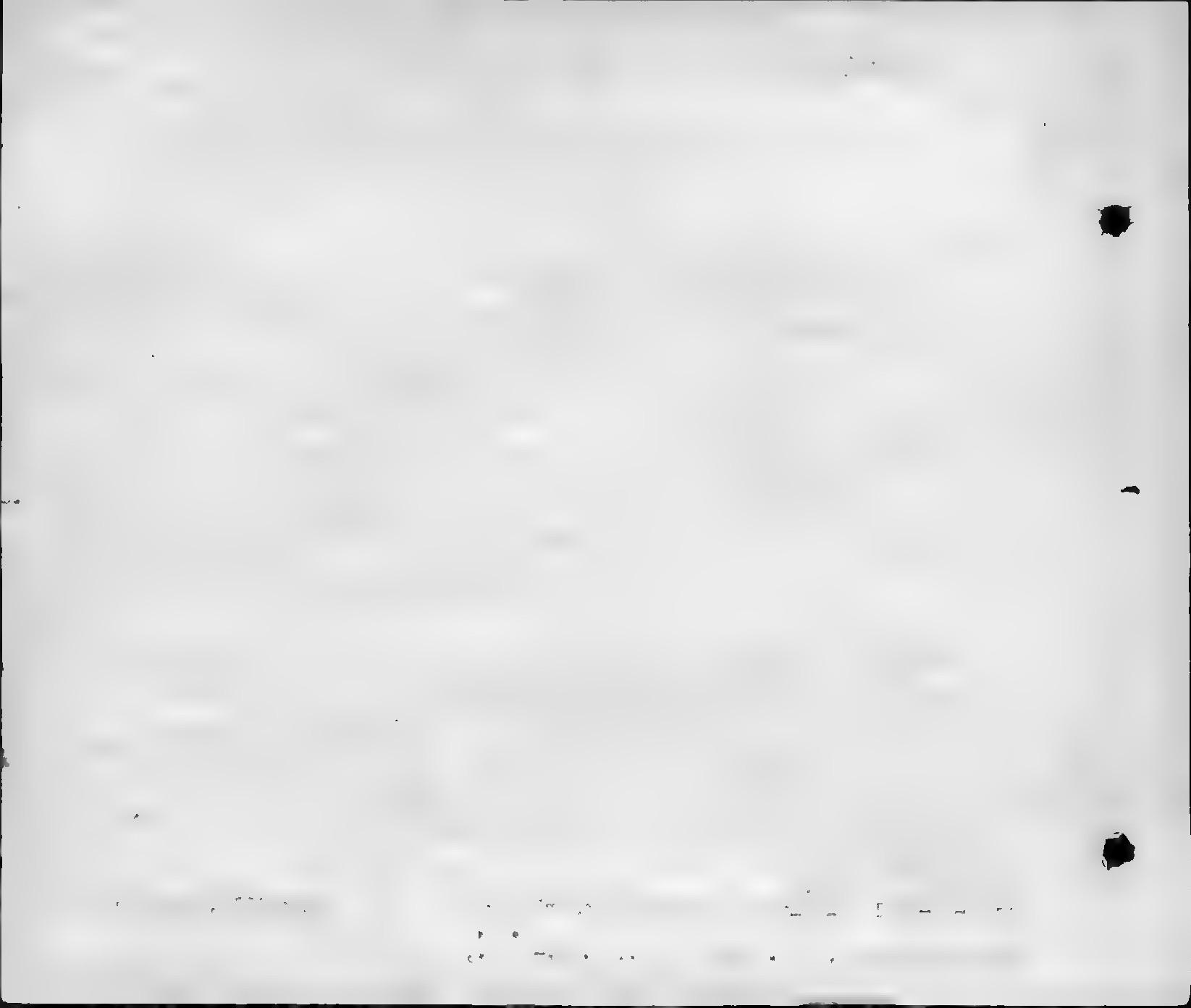
Huntsville, Maryland

23. FUNERAL DIRECTOR ADDRESS D. C. REC'D BY REGISTRAR DATE MAR 24 '61

25

MALVAN & SCHNEY, INC. 424 "R" St., N. W.-Wash., D.C.

Arthur E. Thomas



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If not so retained by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3387

CERTIFICATE OF DEATH

03376

1. PLACE OF DEATH

a. COUNTY MONTGOMERY

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

BETHESDA

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

SUBURBAN HOSPITAL

MARYLAND

c. LENGTH OF STAY IN lb

Since 3/14/61

3. NAME OF
DECEASED
(Type or print)

First EUGENE

Middle Clayton

Last WEEKS

DATE
OF
DEATH

Month MARCH Day 18 Year 19 61

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

7/9/88

9. AGE (In years
last birthday)

72 yrs

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

M.N.

10a. USUAL OCCUPATION (Give kind of work
most of working life, even if retired)

SALESMAN

Retired

10b. KIND OF BUSINESS OR INDUSTRY

Royal McBee

Typewriter Co.

11. BIRTHPLACE (County & State, or foreign country)

New York

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

James T. Weeks

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give rank or dates of service)

YES

16. SOCIAL SECURITY NO.

17. INFORMANT

578-03-4728

Kate Bunting

Address

Mrs. Ida M. Weeks, 3705 Chevy Chase Dr.

Chevy Chase, Md.

18. CAUSE OF DEATH (Indicate only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Multiple Myeloma

INTERVAL BETWEEN
ONSET AND DEATH
about 1 yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While at work
p.m. Not While at work

20d. INJURY OCCURRED

While at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from to , 19 48 to 3/18 , 19 61 that (I) (we) last saw the deceased alive on . 17 mar 19 61 and that death occurred at 330 AM from the causes and on the date stated above

22a. SIGNATURE

William D. Aud

ATTENDING
PHYS. MED.
DIRECTOR STAFF
PHYS.

22b. DATE
SIGNED
3/1/1961

22c. PHYSICIAN'S
NAME (Type)

William D. Aud

22d. ADDRESS

23a. BURIAL, CREMATION OR
REMOVAL (Specify)
BURIAL

3/21/61

23c. NAME OF CEMETERY OR CREMATORIUM
ARLINGTON NAT'L. CEMETERY

23d. LOCATION (City, town or county)

ARLINGTON, VIRGINIA

(State)

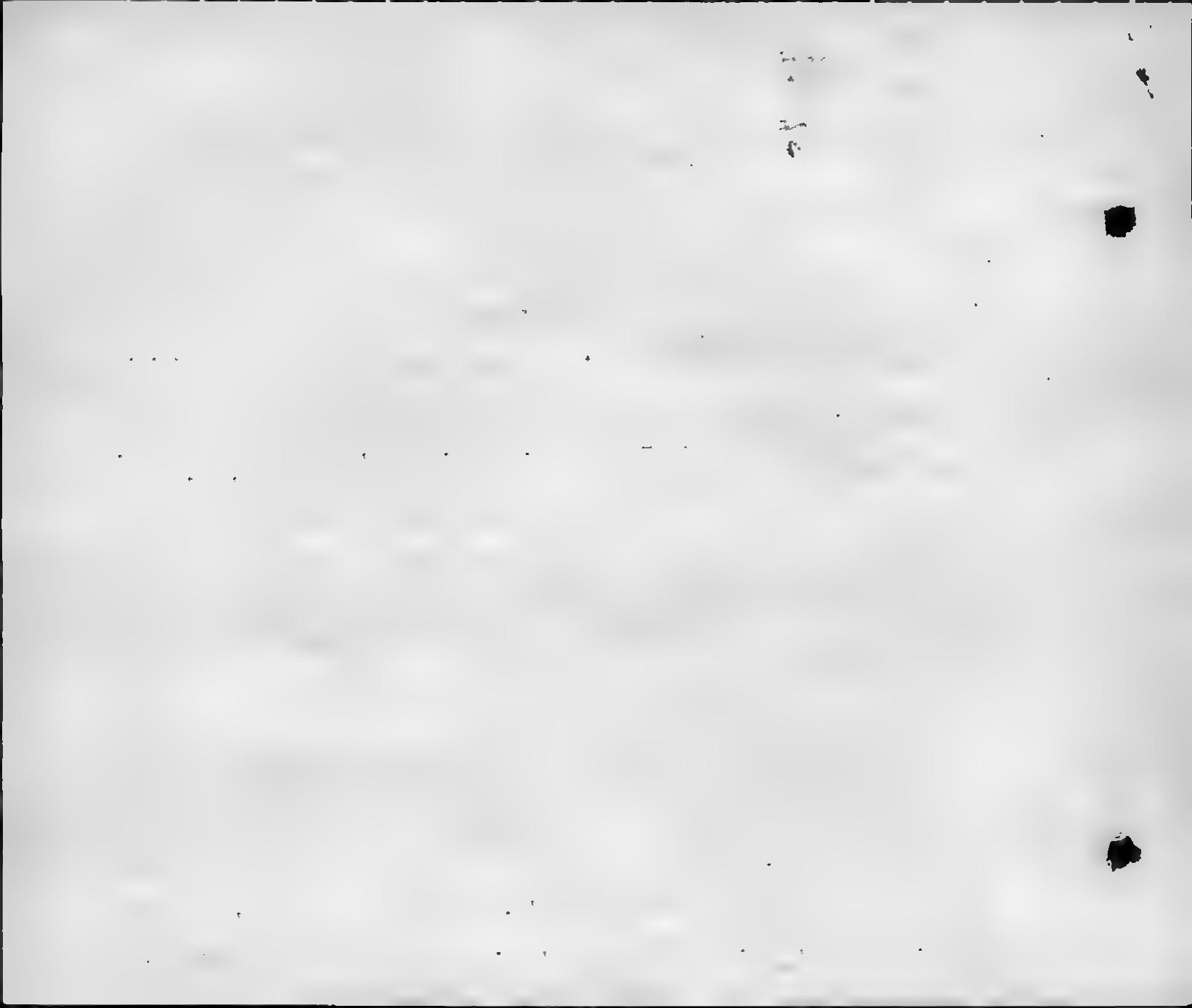
24. FUNERAL DIRECTOR'S SIGNATURE

Raymond E. Pumphrey, Inc.
Raymond E. Zooka

ADDRESS
SILVER SPRING, MD.

25a. REG'D BY REGISTRAR
MAR 23 1961

25b. REGISTRAR'S SIGNATURE
William S. Tamm



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3388

CERTIFICATE OF DEATH

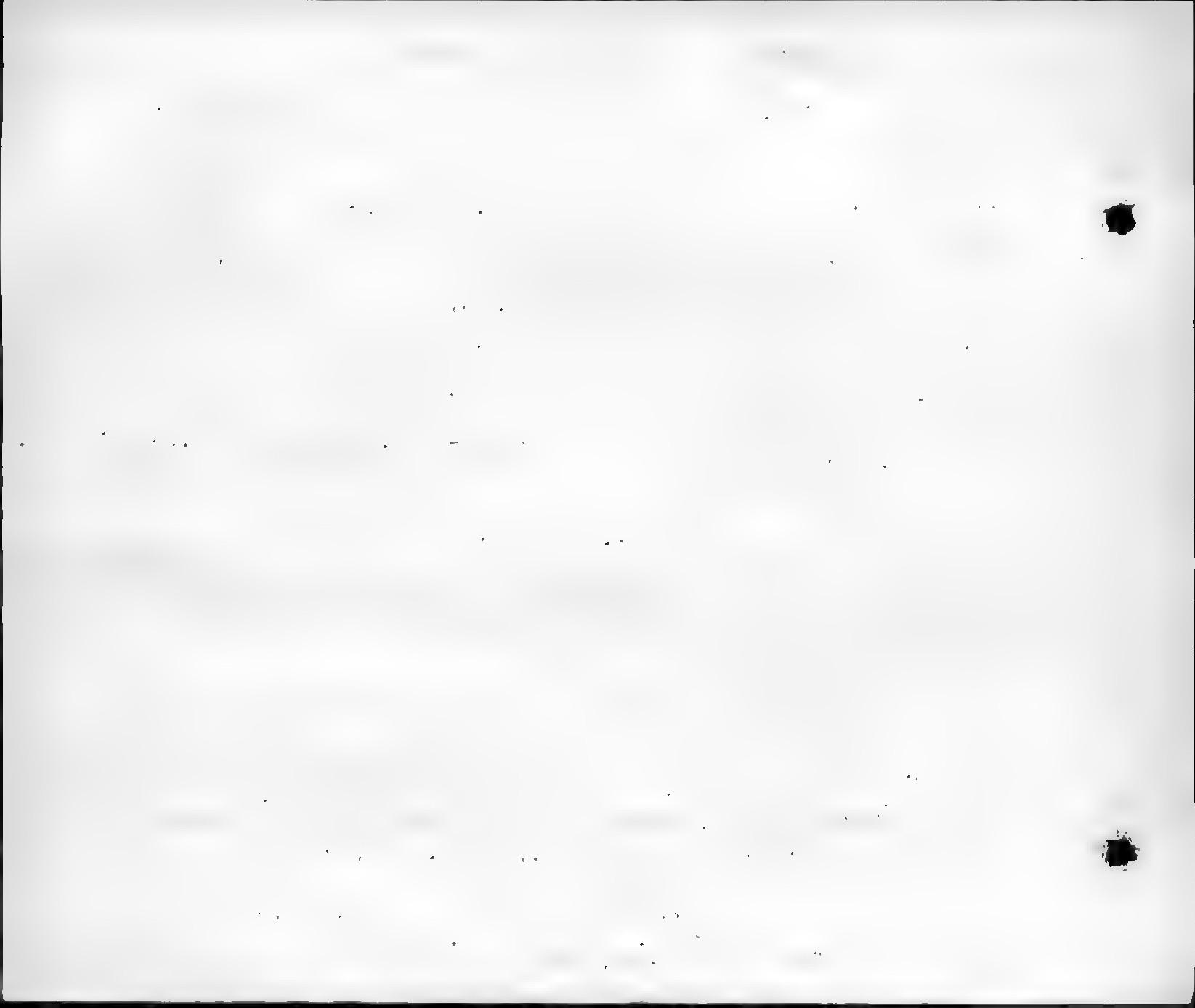
Reg. Dist. No.

03377

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH o. COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE Maryland		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		d. STREET ADDRESS 614 Pershing Drive		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 614 Pershing Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) MARY RAY WATERS WELDEN		First	Middle	Last	4. DATE OF DEATH March 15, 1961	Month	Day	Year
S. SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 15, 1924		9 AGE (In years last birthday) 36 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John B. Waters			14 MOTHER'S MAIDEN NAME Mary Aileen Ray			Address Ryder Ray-200 N. Stonestreet Ave., Rockville, Md.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO			INFORMANT		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days.		
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Woodside, Maryland		(County) (State)
21. I certify that I attended the deceased from Dec. 11, 1959, to March 15, 1961, that I last saw the deceased alive on March 14, 1961, and that death occurred at 1:15 P.M., from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) Aaron H. Traum M.D. 8237 Georgia Ave., Silver Spring, Md. 3/16/61								
DATE SIGNED								
ACTUAL SIGNATURE								
PHYSICIAN'S NAME (Type) Aaron Traum - 8237 Georgia Ave., Silver Spring, Maryland								
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 3/18/61		22c. NAME OF CEMETERY OR CREMATORIUM Grace Church Cemetery		22d. LOCATION (City, town, or county) Woodside, Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE John Wheeler Funeral Home, Rockville, Maryland								
1331 E. Montgomery Ave.				24a. REC'D BY REGISTRAR DATE MAR 20 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Traum		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3389

03378

CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

MARYLAND

c. LENGTH OF STAY IN lb

54 days

d. NAME OF HOSPITAL OR INSTITUTION, if not in hospital, give street address)

U. S. Naval Hospital

3. NAME OF
DECEASED
(Type or print)

4. SEX

Female

5. COLOR OR RACE

Negro

6. MARRIED NEVER MARRIED

WIDOWED

Martha

Coleman

7. DIVORCED

Middle

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

District of Columbia

b. COUNTY

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Washington

d. STREET ADDRESS

2633 12th St., N.E.

478

Month

Day

e. IS RESIDENCE
ON A FARM?
YES NO

Year

WOOTEN

4. DATE
OF
DEATH

March 15

1961

7-16-04

8. DATE OF BIRTH

19. AGE (In years
last birthday) IF UNDER 1 YEAR

56 yrs. Months Days

IF UNDER 24 HRS.
Hours Min.

10. BIRTHPLACE (County & State or foreign country)

North Carolina

11. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Robert WALSTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT
(Yes, no, or unknown) (If yes give rank and dates of service)

No

14. MOTHER'S MAIDEN NAME

Martha J. COBURN

Address

(S) James A. Wooten, same as #2 above

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY;
IMMEDIATE CAUSE (a)

171X DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Renal failure & uremia
Carcinoma of the cervix.

INTERVAL BETWEEN
ONSET AND DEATH

36 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (b) 19. WAS AUTOPSY
PERFORMED?

YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20c. TIME OF INJURY Month, Day, Year

Hour a.m.
p.m.

19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (X) (this hospital) attended the deceased from Jan. 20, 1961 to March 15, 1961, that (X) (we) last saw the deceased alive on March 15, 1961, and that death occurred at 3A.M. from the causes and on the date stated above.

22a. SIGNATURE

Arthur O. Anstil, Jr., LT, MC, USN U. S. Naval Hospital, Bethesda, Md.

22b. DATE SIGNED
3-15-61

22c. PHYSICIAN'S NAME (Type)

Arthur O. ANSTIL, JR., LT, MC, USN U. S. Naval Hospital, Bethesda, Md.

ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.

22d. ADDRESS

23a. BURIAL, CREMATION OR REMOVAL (Specify)

Burial-Shipment

23b. DATE THEREOF

15-3-61

23c. NAME OF CEMETERY OR CREMATORIUM

ADDRESS

23d. LOCATION (City, town or county)

Edgecombe Co.

(State)

No. Carolina

24. FUNERAL DIRECTOR'S SIGNATURE

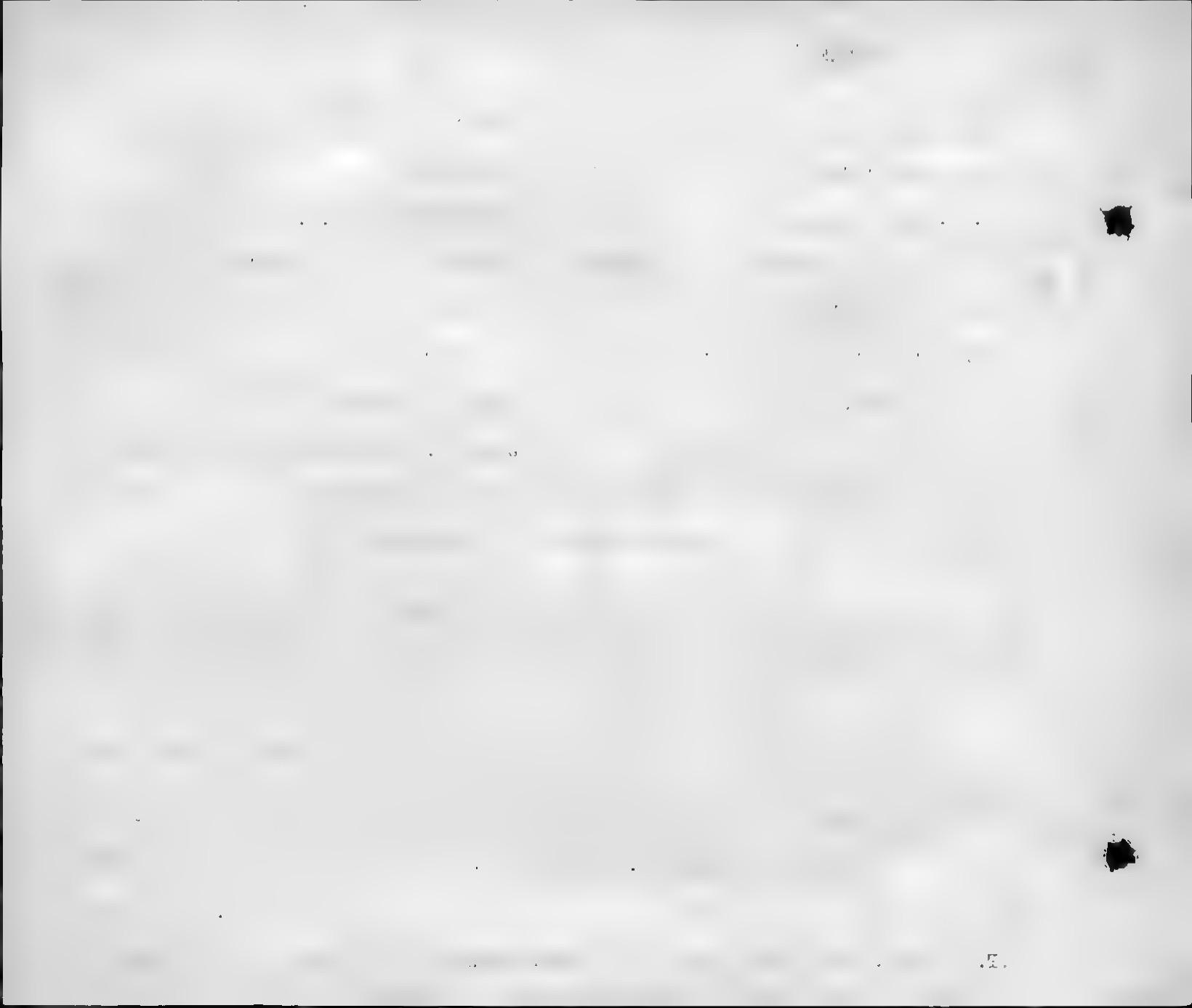
J.T. Rhines Funeral Home, 3015 12th St. NE, WashDC

DATE MAR 21 '61

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03379

3390

1. PLACE OF DEATH a. COUNTY MONTGOMERY			2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE NEW YORK		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON			c. LENGTH OF STAY IN 1b 4 yrs.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KENSINGTON GARDENS NURSING HOME			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First ROBERT	Middle RALEIGH	Last YATES	4. DATE OF DEATH MARCH 6 1961	Month Day Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/10/85	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAPT. U. S. NAVY		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) WARRENTON, VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME HENRY CLAY YATES					
14. MOTHER'S MAIDEN NAME ELIZABETH DESHIELDS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES			16. SOCIAL SECURITY NO. WW #2 & WW #1		
17. INFORMANT Mr. Benjamin R. Yates, Galleon House, St. Thomas Virgin Islands			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
3 PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Stroke DUE TO (c) Cerebral arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 1957 to 3-6-1961	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from....., 1957 to 3-6-1961, that (I) last saw the deceased alive on... 3-6-1961 , and that death occurred at 5:17 PM , from the causes and on the date stated above.					
22a. SIGNATURE Morris Perry			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) MORRIS PERRY			ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION REMOVAL (Specify) CREMATION			23b. DATE THEREOF 3/9/61	23c. NAME OF CEMETERY OR CREMATORIAL FT. LINCOLN CREMATORIAL	23d. LOCATION (City, town or county) PRINCE GEO. COUNTY, MARYLAND
24. FUNERAL DIRECTOR'S SIGNATURE OWNER E. HUMPHREY, INC.			ADDRESS SILVER SPRING, MD	25a. REC'D BY REGISTRAR MAR 15 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

6000

ADDITIONAL INFORMATION

REVIEW OF MATERIALS

REVIEWED

INITIAL

REVIEWED

INITIAL

REVIEWED

INITIAL

REVIEWED

INITIAL

REVIEWED

INITIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3391

CERTIFICATE OF DEATH

03380

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carrollton		d. STREET ADDRESS 8506 Caswell Place,		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year
Male		White	WIDOWED	Young	march 12,	19 61		
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Months	Days Hours Min.
				March 12, 1961			1 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY none			11. BIRTHPLACE (State or foreign country) Maryland		
						12. CITIZEN OF WHAT COUNTRY? America		
13. FATHER'S NAME Charles William Young			14. MOTHER'S MAIDEN NAME Jeanetta Cora Harris					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. no			17. INFORMANT father		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia								
DUE TO Congenital								
(b) A generalized edema (neck, body, scrotum.)								
DUE TO Unknown								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on _____ 19 _____, and that death occurred at _____ M, from the causes and on the date stated above.								
22a. SIGNATURE Herbert J. Friedel			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 3/12/61		
22c. PHYSICIAN'S NAME (Type) Herbert J. Friedel, M. D.			22d. ADDRESS 6826 Riggs Rd., Hyattsville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 3-15-61		23c. NAME OF CEMETERY OR CREMATORIAL Washington Sanitarium and Hospital, Takoma Park, Md.		23d. LOCATION (City, town, or county) (State)		
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M. D. Wash. San. & Hospital		ADDRESS 2075333XV7		25a. REC'D BY REGISTRAR DATE MAR 16 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Krause		

